

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30422

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No.
Primary Registration District No.
(No. 1715 Edmwood)

File No.
Registered No. 3669
St. Ward)

2. FULL NAME

Sarah Rhoades Thomson

(a) Residence. No. 1715 Edmwood 1st Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) apr-25-1845

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>83</u>	<u>4</u>	<u>8</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Raytown
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Geo W Rhoades

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Moberly

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)

14. INFORMANT Bert R Thomson
(Address) 1715 Edmwood

15. FILED 9/4 1928 M. M. Crone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept - 3 1928

I HEREBY CERTIFY That I attended deceased from Aug 23, 1928 to Sept 3, 1928 that I last saw her alive on Sept 3, 1928, and that death occurred, on the date stated above, at 2:03 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Chronic Nephritis
(duration) 12 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF 4
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) W.R. Foster, M. D.

(Address) 1529 Lister

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn - Indep mo DATE OF BURIAL Sept 4 1928

20. UNDERTAKER Newman's Sons ADDRESS F.C. mo

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1529 new

new