

REC'D MAR 9 1939

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

5380

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
(b) Township New Primary Registration District No. 1002 Registered No. 579  
(c) City Kansas City (d) Street No. Memorial Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

(a) Residence, No. 290 Peachy Rhodes St.  Stegginville Mo  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

## MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 11 1939

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Frances Rhodes

22. I HEREBY CERTIFY, That I attended deceased from 2-5, 1939, to 2-10, 19396. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 25 1856

I last saw him alive on 2-10, 1939. Death is said to have occurred on the date stated above, at 3:10 A.M.

7. AGE YEARS 82 MONTHS 7 DAYS 16 IF LESS THAN 1 day, ..... hrs. or ..... min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
9. Industry or business in which work was done, as saw mill, bank, etc. farmer  
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carder Mo

uremia  
139

13. NAME George Rhodes  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

Other contributory causes of importance:

Prostatic Hypertrophy

15. MAIDEN NAME Elizabeth Cowan  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

Name of operation..... Date of.....

What test confirmed diagnosis? Cholesterol Was there an autopsy? no17. INFORMANT (ADDRESS) Sarah Elizabeth Rhodes  
2317 E 839

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE Carder Mo DATE Feb. 11 1939

Manner of injury.....

Nature of injury.....

19. FUNERAL DIRECTOR (NAME) (ADDRESS) O. W. Newcomer Sons  
Brushcreek & Passes

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Clinton Smith M. D.20. FILED 7 11 1939 M.M. Brown  
Local Registrar.(Address) 505 Professional Bldg

copy  
for 6948

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*Nell Carr*  
*3976*

Licensed Embalmer No.....

P. O. Address.....

*1401 Brushch*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**