AUG 29 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25333

Registration District No. 398 Primary Registration District No. 3019 Registrar's No. 195

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Vail Sanitarium (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
In this community years, months or days) About 60 years 211.2

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence (If outside city or town limits, write "RURAL")
(d) Street No. 219 W. Mill (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Elizabeth Rodewald
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John R. Rodewald
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Nov. (Month) 11 (Day) 1870 (Year)

8. AGE: Years 69 Months 8 Days 16 If less than one day hr. min.

9. Birthplace Lawrence (City, town, or county) Kansas (State or foreign country)
10. Usual occupation at home
11. Industry or business
FATHER
12. Name John Maness
13. Birthplace No record (City, town, or county) No. Carolina (State or foreign country)
MOTHER
14. Maiden name Margaret Knight
15. Birthplace (City, town, or county) So. Carolina (State or foreign country)
16. (a) Informant's own signature John R. Rodewald
(b) Address Independence, MO
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/40 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cem.
18. (a) Signature of funeral director Leroy C. Parson
(b) Address Independence MO.
19. (a) July 29/40 (Date received local registrar) (b) F. L. Rook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1940 hour 6:25 minute P. M.
21. I hereby certify that I attended the deceased from Aug. 26, 1931 ~~July 27~~, 19 , to July 27, 1940 that I last saw her alive on July 27, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Lobar Pneumonia	2 to 3 days
Due to Cardio Vascular - renal - Disease c Cardiac Decompensation	2 or 3 yrs
Due to Obesity	
Other conditions (Include pregnancy within 3 months of death)	10

Major findings: Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. H. Allen (M.D. or other) M.D.
Address Independence MO Date signed 7-29-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

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 Ralph E. Miller

Licensed Embalmer No. 4124

P. O. Address Springf. Mo.

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.