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X23159

State File No. _____

Registration District No. 182

Primary Registration District No. 5252

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Christian

(b) City or town Rural Board 5th
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Cleaver, Mo. 1 R#1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Christian

(c) City or town Cleaver
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Julia Rhodes

3. (b) If veteran name war _____ 3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced divorced

6. (b) Name of husband or wife Jasper Rhodes 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 23-1969
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>9</u>	<u>28</u>	hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business _____

12. Name Joe Chastain

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ethel Pearce
(b) Address Cleaver, Mo.

17. (a) Burial (b) Date thereof Feb 26-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frazier Chapel

18. (a) Signature of funeral director J.W. Maple
(b) Address Cleaver, Mo.

19. (a) Feb 28, 1941 (b) Gerta Hicks
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21st
year 1941 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from January 20 1941, 19____, to February 21/1941; that I last saw h. er alive on Feb 21 1941, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hyperstension

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:
Of operations _____
Of autopsy _____

Duration _____

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? _____

While at work? _____
(Specify type of place) (a) Means of injury

23. Signature [Signature] (If D. P. or other) _____
Address Public Mo. Date signed _____

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

RECEIVED

District Health Officer No. 6,

District File Number 341-364

Date Filed MAR 5 1941

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.....

J.W. Maples

Licensed Embalmer No. 2985

P. O. Address Cliner m

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, fact should be so stated above.