

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9757

State File No. \_\_\_\_\_

1166

Registrar's No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Marcy Hospital, Kansas City, Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution About 1 hour.  
(Specify whether  
In this community 3 months  
years, months or days)

9. (a) PRINT FULL NAME Charles Franklin Rhodus

8. (b) If veteran, name war X X 8. (c) Social Security No. X X

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

6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Nov. 30 1940  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 3 20 hr. min.

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

10. Usual occupation X

11. Industry or business X

12. Name Charles Lester Wilson

13. Birthplace Morgan County Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Ida Mae Rhodus

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

16. (a) Informant Ida Mae Rhodus

(b) Address Raytown, Missouri.

17. (a) Burial (b) Date thereof Mar. 23 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookings Cemetery

18. (a) Signature of funeral director Clayton

(b) Address Raytown, Missouri.

19. (a) 3/27/1941 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Raytown,  
(If outside city or town limits, write "RURAL")  
(d) Street No. X X X  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 28  
year 41 hour 12:10 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death acute pharyngitis with terminal pneumonia  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 107  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy see above

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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M, D, or other) 3/27/41  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

48  
398

48  
0

MOTHER FATHER

**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

*E. Clark Stegert*

Licensed Embalmer No.

*3983*

P. O. Address

*Raytown 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.**