

No. 2  
13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9947**

**APR 15 1941**

Registration District No. **30**

Primary Registration District No. **3003**

Registrar's No. **17**

1. PLACE OF DEATH: *Barry, Missouri Mo.*

(a) County *Barry*

(b) City or town *Monette Mo.*

(c) Name of hospital or institution: *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 *3 years* years, months or days

3. (a) PRINT FULL NAME *Mattie Leone Rhoads*

3. (b) If veteran, name war *no*

3. (c) Social Security No. *none*

4. Sex *Female* 5. Color or race *white*

6. (a) Single, widowed, married, divorced *widowed*

6. (b) Name of husband or wife *deceased*

6. (c) Age of husband or wife if alive *5* years

7. Birth date of deceased *Nov 12 - 1875*

(Month) (Day) (Year)

8. AGE: Years *65* Months *3* Days *21* If less than one day hr. min.

9. Birthplace *Mattoon Ill.*

(City, town, or county) (State or foreign country)

10. Usual occupation *House Wife*

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name *James Parks*

13. Birthplace *Indiana*

(City, town, or county) (State or foreign country)

14. Maiden name *Gynthia M. Lemon*

15. Birthplace *Indiana*

(City, town, or county) (State or foreign country)

16. (a) Informant *Floyd P. Rhoads*

(b) Address *Rogers Ark.*

17. (a) *Removal* (b) Date thereof *3-5-1941*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Rogers Ark.*

18. (a) Signature of funeral director *Callison, F. Home*

(b) Address *Rogers Ark.*

19. (a) *3-3-1941* (b) *W. M. West*

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Barry*

(c) City or town *Monette*

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

(d) Street No. *700 Lincoln*

(If rural, give location)

(e) If foreign born, how long in U. S. A? *0* years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* day *3*

year *1941* hour *8:30* minute *17* A. M.

21. I hereby certify that I attended the deceased from *Dec. 31 - 1940 to Mar 3 - 1941*

that I last saw *her* alive on *Mar. 3*, 19*41*

and that death occurred on the date and hour stated above.

Immediate cause of death *Myocarditis*

Due to *hypertension and arteriosclerosis*

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

Other conditions (Include pregnancy within 3 months of death)

*A. H. Ferguson*

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? *31*

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature *L. H. Ferguson* (M. D. or other) \_\_\_\_\_

Address *Monette Mo.* Date signed *3-3-41*

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

RECEIVED

District Health Officer No. 8,

District File Number

441-629

Date Filed

APR 12 1941

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**