

FILED APR 21 1941

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

11248

Do not use this space.

## 1. PLACE OF DEATH

(a) County Linn Registration District No. 496  
 (b) Township Brookfield Primary Registration District No. 3025 Registered No. 3661  
 (c) City Brookfield (d) Street No. McLannan 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 33 yrs. 1 mos. 3 ds. (f) How long in U.S., if of foreign birth? 33 yrs. 1 mos. 3 ds.

## 2. PRINT FULL NAME

MARY BELLE RHODES  
 (a) Residence, No. 7 New Cambria, Mo. RR10 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county of city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 22, 1908</u>		
7. AGE	YEARS <u>33</u>	MONTHS <u>1</u>
	DAYS <u>3</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>School Teacher</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u></u>	
	10. Date deceased last worked at this occupation (month and year) <u></u>	
11. Total time (years) spent in this occupation <u></u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>New Cambria Mo.</u>		
FATHER	13. NAME <u>Lee Rhodes</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Macon Pa.</u>	
MOTHER	15. MAIDEN NAME <u>Rosetta York</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Macon Pa.</u>	
17. INFORMANT (ADDRESS) <u>Oral Rhodes Memphis, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>New Cambria Mo.</u> DATE <u>3/27</u> , 19 <u>41</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Stephens &amp; Gooding Macon, Mo.</u>		
20. FILED <u>3-28-1941</u> <u>Macon Mo.</u> Local Registrar.		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25, 1941

22. I HEREBY CERTIFY, That I attended deceased from March 10, 1941, to March 25, 1941  
 I last saw her alive on 3-25, 1941. Death is said to have occurred on the date stated above, at 10:25 a.m.  
 The principal cause of death and related causes of importance were as follows:

<u>Pneumonia</u>	Date of onset <u>2da</u>
<u>Septicemia</u>	<u>13da</u>
<u>Shock</u>	<u>3mo</u>

Other contributory causes of importance:  
Septicemia  
Shock

Name of operation None Date of 0  
 What test confirmed diagnosis? Smear Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? 0 Date of injury 0, 1941  
 Where did injury occur? 0 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury 0  
 Nature of injury 0

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify 0  
 (Signed) John M. Hays M. D.  
 (Address) Brookfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

I X1-1023

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor-

Dr John H. Francis  
Branford, Mo

276

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed *C. L. Stephens*

Licensed Embalmer No. *3057*

P. O. Address *Macon, 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.**

Registration District No. 496

Primary Registration District No. 3025

Registrar's No.

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brookfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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)

3. (a) PRINT FULL NAME Mary Belle Rhodes

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 1 3 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant..... (b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

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

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits, write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) Citizen of foreign country..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15  
year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....  
that last saw h..... alive on....., 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

acute myocarditis  
Due to.....  
Due to.....

Other conditions acute hepatitis  
(Include pregnancy within 3 months of death)  
and gall bladder inf.

Major findings.....  
Of operations.....  
Of autopsy.....  
PHYSICIAN.....  
Underline the cause to which death should be charged etiologically.

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 J. H. Murray (M. D. or other)  
Address Brookfield Mo Date signed 6/24/47

SUPPLEMENTAL

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

MOTHER FATHER

1941  
S-11248