

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **24263**  
Registrar's No. **2802**

**FILED AUG 10 1943**

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:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-2-41-7-21-41  
(Specify whether years, months or days) 6 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1419 E. 22nd St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 21  
year 41 hour 6 minute 30 P. M.

21. I hereby certify that I attended the deceased from  
1-2- 1941 to 7-21- 1941;  
that I last saw her alive on 7-21- 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral sclerosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)  
Generalized arteriosclerosis  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
Address Gen. Hosp #2 Date, signed 7-22-41

3. (a) PRINT FULL NAME Amanda Harris Rhone

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

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Feb. 8, 1895  
(Month) (Day) (Year)

8. AGE: Years 46 Months 5 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business none

12. Name Leonard Huey Ark.

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

14. Maiden name Carrie Reynolds Ark.

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

16. (a) Informant Redford Clerk

(b) Address General Hospital #2

17. (a) \_\_\_\_\_ (b) Date thereof July 26, 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director [Signature]

(b) Address 2205 W. 26th St. Crown

19. (a) 7-26-41 (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

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

2000

**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.....

*B. L. Graham*

Licensed Embalmer No. *25740*

P. O. Address *2208 Knelt*

**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.**