No. 2
1-4-41
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 30 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31664

Registration District No. 384 Primary Registration District No. 4227 Registrar's No.

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

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46

(c) City or town West Plains /
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Patricia Sue Rhoads

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Fem /

5. Color or race White

6. (a) Single, widowed, married, divorced 0 Infant

6. (b) Name of husband or wife

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

7. Birth date of deceased July 28, 1941
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
0	0	9	hr. min.

9. Birthplace West Plains, 0 Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Cleo Rhoads
13. Birthplace Montgomery Co., 0 Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Maxine Wheat
15. Birthplace Douglas Co., 0 Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Cleo Rhoads
(b) Address West Plains, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8-41
(Month) (Day) (Year)

(c) Place: burial or cremation Amy Cemetery

18. (a) Signature of funeral director Cleo Rhoads
(b) Address West Plains, Mo.

19. (a) 8-8-41 (Date received local registrar) (b) Vida W Simons (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7
year 1941 hour 6 minute P M.

21. I hereby certify that I attended the deceased from July 28, 1941 to August 7, 1941;
that I last saw her alive on August 2, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchial pneumonia, acute	7 days
Due to Mucous in lungs from date of	
Due to birth, 7-28-41	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature A. H. Thornburgh, M.D. (M. D. or other)
Address West Plains, Mo. Date signed

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5
District File Number 8-1-1969
Date Filed

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.