

No. 2  
1-4-41  
17-39  
X26350

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED NOV 13 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33743

Registration-District No. 399

Primary Registration District No. 1002

Registrar's No. 3624

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Months  
In this community 30 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
Missouri Jackson 048  
(a) State (b) County  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 523 W. 12th St., 2  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM Carl RHODES  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 9 day 30 year 1941  
hour 1:45 minute P

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Mrs. Nora Rhodes 6. (c) Age of husband or wife if alive 64 years  
7. Birth date of deceased Jan. 7, 1874  
(Month) (Day) (Year)

21. I hereby certify that William C. Rhodes died from Extensive trophic ulcers over the sacrum and both humeri with osteomyelitic fracture of left femur  
that last fully alive on 10/2/41 and that death occurred on the date and hour stated above.  
Immediate cause of death Extensive trophic ulcers over the sacrum and both humeri with osteomyelitic fracture of left femur

8. AGE: Years 67 Months 8 Days 23 If less than one day hr. min.  
9. Birthplace St. Paul Minnesota  
(City, town, or county) (State or foreign country)

Other conditions Arteriosclerosis  
Major findings:  
Of operations None  
Of autopsy Yes

10. Usual occupation Blacksmith  
11. Industry or business Turkey Creek Pumping Station  
12. Name William C. Rhodes  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Bertha Horick  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Nora Rhodes  
(b) Address 523 W. 12th St.,  
17. (a) Burial (b) Date thereof Oct. 2, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 9-8-41  
(c) Where did injury occur? K.P. Mo 123  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial plant, or in public place?  
Industrial plant  
(Specify type of place) (e) Means of injury 3

18. (a) Signature of funeral director C. H. BLACKMAN & SON, INC.  
(b) Address 2825 Indep. Blvd., K. C. Mo.  
19. (a) 10/2/41 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

23. Signature W. C. Rhodes (M. D. or other) 3  
Address K.P. Mo Date signed

**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.....

*Wilton L. Kealy*

Licensed Embalmer No.....

*4225*

P. O. Address.....

*Independence, 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, fact should be so stated above.**