

FILED APR 14 1943  
Registration District No. 2

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
2518 North 15th Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Not  
(Specify whether years, months or days)

In this community 32 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 2518 North 15th Street  
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Mary 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, widow

6. (b) Name of husband or wife Jack Rhoads

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased January 24 1870  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>1</u>	<u>12</u>	<u>hr. min.</u>

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Arnold T. Waldon

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

14. Maiden name Rachel P. Leard

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

16. (a) Informant Family Bible

(b) Address 2518 No. 25th. St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof 3-10-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Mt. Washington Cemetery Kansas City, Mo.

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 13th. & Faraon St. St. Joseph, Mo.

19. (a) 3-10-43 (b) Rose Herzog  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar, day 7th  
year 1943, hour 10 minute a M.

21. I hereby certify that I attended the deceased from Mar 7th 1943 to 1943;  
that I last saw h. alive on 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 day  
Chronic Myo-Carditis 2 yrs  
General Arteriosclerosis 2 yrs

Other conditions Woman died suddenly while alone in her home following complaint of no shortness of breath and weakness

Major findings: no shortness of breath and weakness

Of autopsy no shortness of breath and weakness

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) 930

(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)

(e) Means of injury While at work?

23. Signature H. Munday (M.D. or other) Coroner

Address 104 So 3d St Date signed 3/11/43

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

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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.....

*Geo E. Daniel*

Licensed Embalmer No. 3300 Missouri.

P. O. Address. St. Joseph, Missouri.

**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.**