

No. 2  
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17-39  
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Roy

14208

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAY 12 1943

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Clay Township  
(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 years, months or days)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_ 35

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL") 9

(d) Street No. \_\_\_\_\_ (If rural, give location) 9

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CORA ANN RHODES

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 2 year 1943 hour 1 minute 30 A. M.

21. I hereby certify that I attended the deceased from 4-30-43 1943 to 5-2-43 1943 that I last saw her alive on 5-1 1943 and that death occurred on the date and hour stated above.

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 \_\_\_\_\_ years

7. Birth date of deceased 3 14 1941  
(Month) (Day) (Year)

Immediate cause of death Bronchial Pneumonia

Due to Influenza

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 33a

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration 4 days

about 4-28-43

8. AGE: Years Months Days If less than one day

2 1 18 hr. min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Eric Rhoads

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

14. Maiden name Bertine Johnson

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

16. (a) Informant Eric Rhoads

(b) Address Senath MO

17. (a) \_\_\_\_\_ (b) Date thereof 5-2-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lula Cemetery

18. (a) Signature of funeral director Dr. Daniel S. ...

(b) Address Senath MO

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

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? \_\_\_\_\_

23. Signature Roy Rhodes (Specify type of place) \_\_\_\_\_ (M. D. or other) MD

Address Senath MO Date signed 5-2-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

7  
143

1201

MAY 1 1938

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.....

*not Embalmed*

Registered Apprentice No. ....

working under my personal supervision.

Signed *A. S. McDaniel*

Licensed Embalmer No. *2093*

P. O. Address *Senath, Wis*

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 15

Registration District No. (103)

Primary Registration District No. (5417)

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Clay Township RURAL  
(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 \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Cora Ann Rhoder

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 5

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

7. Birth date of deceased March 14 (Month) (Day) (Year)

8. AGE: Years 2 Months 1 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name Eric Rhoder  
13. Birthplace Senath, Mo (City, town, or county) (State or foreign country)  
14. Maiden name Pauline Johnson  
15. Birthplace Senath, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Eric Rhoder

(b) Address Senath, Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 5-2-43 (Month) (Day) (Year)

(c) Place: burial or cremation Like cemetery

18. (a) Signature of funeral director McDonnell Juniper

(b) Address Senath, Mo

19. (a) May 10 1943 (Date received local registrar) (b) Spencer B. Reilly (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DUNKLIN  
(c) City or town HORNERSVILLE RURAL  
(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 MAY Day 2  
Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death bronchial pneumonia

Due to influenza Duration 4 days

Due to \_\_\_\_\_ about 4-25-43

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY 2

RECEIVED

District Health Office No. 2,

District File Number 643-827

Date Filed 6-10-48

S-14208