

Registration District No. **5575**

Primary Registration District No. **5575**

Registrar's No. **67**

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

1. PLACE OF DEATH:

(a) County **Jackson (Rural)**
(b) City or town **Hickman Mills**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **(Washington Co.)**
91st & Prospect Ave.
(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)

3. (a) PRINT

FULL NAME **Roy Joseph Rhodes**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 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 **August 16, 1943**
(Month) (Day) (Year)

8. AGE: Year _____ Months _____ Days _____ If less than one day **13 Hours**
hr. min.

9. Birthplace **Hickman Mills, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name **Roy Rhodes**

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

14. Maiden name **Julma Mary Depont**

15. Birthplace **K.C. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Roy Rhodes**

(b) Address **91st & Prospect Ave.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8-17-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Thos. E. Quisk Funeral Home**

(b) Address **4316 Troost Ave.**

19. (a) **10-10-43** (Date received local registrar) (b) **Dr. Annie G. Deages** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**
(c) City or town **Hickman Mills, Mo.**
(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 **August 16, 1943**
year _____ hour **10 P.M.** minute _____ M.

21. I hereby certify that I attended the deceased from **Aug 16, 1943** to **Aug 19, 1943**
that I last saw ~~him~~ **her** alive on **Aug 14, 1943**
and that death occurred on the date and hour stated above.
Immediate cause of death **Atelectasis 13 hours** Duration _____

Due to **Premature birth**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **159**
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? _____

_____ (Specify type of place)
_____ (e) Means of injury

23. Signature **R. C. Bagan** (M. D. or other) _____

Address **404 1/2 W. 7th St.** Date signed **10-9-43**

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..... *Thomas J. Jenik*

Licensed Embalmer No..... *3775*

P. O. Address..... *N. O. 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.