

FILED DEC 6 1943
120

Registration District No. _____

Primary Registration District No. **5353**

1. PLACE OF DEATH:

(a) County **GREENE** **DALLAS**
(b) City or town **ELKLAND** **M.R.F.D. # 2**
(c) Name of hospital or institution: **Jackson tw**
(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 **Mo.** (b) County **Dallas 30**
(c) City or town **Elkland Jackson tw**
(If outside city or town limits, write "RURAL")
(d) Street No. **R.F.D. # 2**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **ALBERT NOAH RHOTEN**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **LYDIA ANN RHOTEN** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 27 1888**
(Month) (Day) (Year)

8. AGE: Years **75** Months **3** Days **6** If less than one day _____ hr. _____ min.

9. Birthplace **Jere Haute Ind. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Farming**

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Elmer V. Rhoten**

(b) Address **R# 5 Springfield, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 5-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Green Mountain**

18. (a) Signature of funeral director **J. W. Kingner & Co.**

(b) Address **Springfield, Mo.**

19. (a) **Nov. 9, 1943** (b) **Mrs. A. L. Homer**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **3**
year **1943** hour **9** minute **00 A.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Duration _____

Due to _____

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 **3**

23. Signature **S. B. Jones** (M. D. or other) _____

Address **Buffalo Mo** Date signed **Nov 5 1943**

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

MOTHER FATHER

1124

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District No. 11-43-1271
Date Filed 12-2-43

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.....

Licensed Embalmer No. 4071

P. O. Address Springfield

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.