

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8813**

FILED MAR 26, 1947

Registration District No. **37**

Primary Registration District No. **4218**

Registrar's No. **58**

1. PLACE OF DEATH:

(a) County **Henry**
(b) City or town **Windsor**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 Weeks**
(Specify whether years, months or days)
In this community **3 months**

3. (a) PRINT FULL NAME **Mrs. Amy Kahl Rhodes**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **No.**

4. Sex **Fe** / 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**
6. (b) Name of husband or wife **Dr. E. L. Rhodes** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 23 1866**
(Month) (Day) (Year)

8. AGE: Years **80** Months **11** Days **21** If less than one day hr. _____ min. _____

9. Birthplace **Benton County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **at home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Peter Kahl**
13. Birthplace **unknown Pennsylvania**
(City, town, or county) (State or foreign country)
14. Maiden name **Amanda Spangenberg**
15. Birthplace **unknown New York**
(City, town, or county) (State or foreign country)

16. (a) Informant **Paul E. Linscomb**
(b) Address **Alhambra, Calif**

17. (a) **Burial** (b) Date thereof **3-16-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln, Missouri**

18. (a) Signature of funeral director **Auston Jumble**
(b) Address **Windsor, Mo.**

19. (a) **3-19-47** (b) **R. R. Kenney**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Benton**
(c) City or town **Lincoln**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14**
year **1947** hour **3:30 p** minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 21**
1947 to **March 14** 19**47**
that I last saw him alive on **March 14** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Thrombosis - 2d**
Angina Pectoris 3-10

Due to _____
Due to _____

Other conditions: **Respiratory Infection 3-10**
Probable Influenza 3-14

Major findings: _____
Of operations _____
Of autopsy **APP 1**

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 **R. R. Kenney** (M. D. or _____)
Address **Windsor, Mo.** Date signed **3-15**

(Licensed Embalmer's Statement on Reverse)

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

42
2
0

120

447

RECEIVED
District Health Officer No. 7,
District File Number 8-47-314
Date Filed 3-25-47

SEP 20 1958

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.....

William M. Turner

Registered Apprentice No. *470*

working under my personal supervision.

Signed.....

Eldon Keston

Licensed Embalmer No. *3391*

P. O. Address *Windsor, 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.