

FILED AUG 26 1947

Registration District No. 53

Primary Registration District No. 3010

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution one day
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Infant Sonya Ann Rhodes

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Infant

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

7. Birth date of deceased July 26, 1947
(Month) (Day) (Year)

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

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

10. Usual occupation Inf

11. Industry or business _____

12. Name Ann Rhodes

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

14. Maiden name Helen Gimmes

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

16. (a) Informant Cecil Rhodes
(b) Address Advance, Mo

17. (a) Burial (b) Date thereof July 29, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Hill Cemetery

18. (a) Signature of funeral director Raymond Morgan
(b) Address Advance, Missouri
19. (a) 8-22-1947 (b) C. G. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1947 hour 3 minute 5 P.M.

21. I hereby certify that I attended the deceased from 7/28, 1947, to 7/29, 1947, that I last saw him alive on 7/29 and that death occurred on the date and hour stated above.

Immediate cause of death Stenosis of the Esophagus congenital
Due to _____

Due to Confirmed by X-Ray
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy 157/15

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)
(c) Means of injury U

23. Signature Chas. J. Herlihy (M. D. or other) _____
Address Cape Girardeau, Mo.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

16
14

RECEIVED

District Health Officer No. 4
District File Number 847-1093
Date Filed 8-25-47

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.....

P. O. Address.....

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.