

FILED AUG 21 1947

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

28438

Do not use this space.

1. PLACE OF DEATH  
(a) County Neodesha Registration District No. 237  
(b) Township Anderson Primary Registration District No. 5820  
(c) City Anderson Mo Street No. 1 St. 0  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. 0
2. PRINT FULL NAME Jackie Wayne Rhodes  
(a) Residence, No. Neodesha Co Mo St.  (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 3 1947  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. 0  
9. Industry or business in which work was done, as saw mill, bank, etc. 0  
10. Date deceased last worked at this occupation (month and year) 0 11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Anderson Mo

- FATHER 13. NAME Jackson Rhodes  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo Ark

- MOTHER 15. MAIDEN NAME Dorothy May Mabrey  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Little Rock Ark

17. INFORMANT (ADDRESS) Jackson Rhodes

18. BURIAL, CREMATION, OR REMOVAL PLACE Blainfield DATE Aug 5 1947

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Clayd Kurbell  
1001 1/2 Anderson

20. FILED Aug 11, 1947 Mrs. Byron Sherr  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 4 1947

22. I HEREBY CERTIFY, That I attended deceased from Aug 3 1947, to Aug 4 1947  
I last saw him alive on Aug 4 1947 Death is said to have occurred on the date stated above, at 5:30 m.

The principal cause of death and related causes of importance were as follows:

undeveloped tarsals Date of onset

Other contributory causes of importance:

Name of operation none Date of 15th hour  
What test confirmed diagnosis? clench Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
accident, suicide, or homicide? no Date of injury none

Where did injury occur? none  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none  
Nature of injury none

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify no  
(Signed) W. B. Elliot, M. D.  
(Address) Anderson Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

I X 14022

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Office No. 2,

District File Number 8-4-1100

Date Filed 2-19-47

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**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, above space should be left blank.**