

No. 2  
12-45  
17-39  
X47070

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 7 1948**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30599**  
Registrar's No. **279**

Registration District No. **274** Primary Registration District No. **3052**

1. PLACE OF DEATH:  
(a) County **Pettis**  
(b) City or town **Sedalia**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**1011 W. 7th St.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **6 Weeks**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Pettis**  
(c) City or town **Sedalia**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1011 W. 7th St.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **SUE MAE THOMSON RHEA**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex **F** 5. Color or race **W**  
6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **Thomas L. Rhea**  
6. (c) Age of husband or wife **alive** years \_\_\_\_\_  
7. Birth date of deceased **April 14, 1879**  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
**69 5 8** hr. min.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept.** day **22nd**  
year **1948** hour **6:30** minute **a** M.  
21. I hereby certify that I attended the deceased from **June 24, 1948** to **Sept 22, 1948**  
that I last saw her alive on **Sept 21, 1948**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Ch. Valvular Heart Disease**  
Due to **Rheumatic Fever**  
Due to \_\_\_\_\_  
Other conditions **Ch. Bronchopneumonia**  
(Include pregnancy within months of death)  
Major findings **refertis**  
Of operations \_\_\_\_\_  
Of autopsy **131B**

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 **0**  
23. Signature **[Signature]** (M. D. or other) **M.D.**  
Address **Sedalia Mo** Date signed **9/24/48**

MOTHER FATHER

9. Birthplace **Slater Mo.** (City, town, or county) (State or foreign country)  
10. Usual occupation **At Home**  
11. Industry or business \_\_\_\_\_  
12. Name **Robert K. Thomson**  
13. Birthplace **Slater Mo.** (City, town, or county) (State or foreign country)  
14. Maiden name **Mary Plant**  
15. Birthplace **Monticello Mo.** (City, town, or county) (State or foreign country)  
16. (a) Informant **L. Berta Thomson**  
(b) Address **Sedalia, Mo.**  
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-24-1948** (Month) (Day) (Year)  
(c) Place: burial or cremation **Smithton Cemetery**  
18. (a) Signature of funeral director **[Signature]**  
(b) Address **Sedalia, Mo.**  
19. (a) **9-24-48** (Date received local registrar) (b) **Betty Yeager** (Registrar's signature) **Deputy**  
(Licensed Embalmer's Statement on Reverse Side)

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 10-6-48

8161 2150

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 John A. Cantlon  
Licensed Embalmer No. 4387  
P. O. Address Sedalia, 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.