

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 1 1950

State File No. 20420
2682

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY	
c. LENGTH OF STAY (In this place) 58 yrs		d. STREET ADDRESS (If rural, give location) 1821 Jarboe Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL HOSPITAL #2			

3308

3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) RHODES c. (Last) RHODES			4. DATE OF DEATH (Month) (Day) (Year) JUNE 12 1950		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH SEPTEMBER 7 1884	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY K.C. TERMINAL	11. BIRTHPLACE (State or foreign country) TENNESSEE	12. CITIZEN OF WHAT COUNTRY? U. S.	

13a. FATHER'S NAME BEN RHODES	13b. MOTHER'S MAIDEN NAME ROSA HARRIS	14. NAME OF HUSBAND OR WIFE MARION RHODES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 703-03-8147	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MARION RHODES 1821 Jarboe Avenue

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RESPIRATORY FAILURE		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIO VASCULAR DISEASE		443X
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. OLD CEREBRAL VASCULAR ACCIDENT		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-6, 1950, to 6-12, 1950, that I last saw the deceased alive on 6-12, 1950 and that death occurred at 7:00P m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Billie (Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 6-13-50
-------------------------------------------------------------------	------------------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/16/50	24c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
---------------------------------------------------------	--------------------------	------------------------------------------------------------	----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 6-16-50	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter L. Has. 1729 Lydia
-----------------------------------------	------------------------------------------------	---------------------------------------------------------------------------

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *E. Jerome Malone*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.