

FILED AUG 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25210**
6483

BIRTH NO. <u>45979-50</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1005</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis 2069</u>		d. STREET ADDRESS (If rural, give location) <u>4817 Easton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Park Lane Memorial Hosp</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 27 50</u>			
3. NAME OF DECEASED (Type or Print) <u>Infant Bats</u>		b. (Middle) _____		c. (Last) <u>Rhodes B</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>New Born</u>		8. DATE OF BIRTH <u>7-27-50</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Charles Edgar Rhodes</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Jane Scott</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If no, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Betty Rhodes</u> ADDRESS <u>4817 Easton</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature 6 1/2 months</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>_____</u> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		21f. HOW DID INJURY OCCUR? <u>796X</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>July 22, 1950</u> , to <u>July 27, 1950</u> , that I last saw the deceased alive on <u>July 27, 1950</u> and that death occurred at <u>11:45pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Olysee B. Kane</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>706 Welton</u>		23c. DATE SIGNED <u>7-28-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-29-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>1215 Lemay Ferry Road Mo</u>	
DATE REC'D BY LOCAL REG. <u>JUL 29 1950</u>		REGISTRAR'S SIGNATURE <u>Jr B. Sautter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jiegenlen Bens</u> ADDRESS <u>6409 Gravois Ave</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *No Embalmer*

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.