

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24127

State File No.

BIRTH NO.		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>159</u>					
1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Charles</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY OR TOWN <u>Alto Pass</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St Joseph Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>Alto Pass Ill</u> <u>8120 S</u>							
3. NAME OF DECEASED (Type or Print) <u>Etta Rhodes</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>July 21 1954</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 27 1890</u>					
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Alto Pass Ill</u>					
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>John Hancock</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Farmer</u>		14. NAME OF HUSBAND OR WIFE <u>Lewis Rhodes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Kathleen Whitaker Alto Pass Ill.</u>				ADDRESS			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Gen. arterio Sclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Left Hemiplegia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u> <u>1 days</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>						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)		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 <u>7-20-54</u> , 19 <u>54</u> , to <u>7-21-54</u> , 19 <u>54</u> ; that I last saw the deceased alive on <u>7-20-54</u> , and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.											
23a. SIGNATURE <u>R J Rend (C)</u>				(Degree or title) <u>MD</u>		23b. ADDRESS <u>St Charles, MO</u>		23c. DATE SIGNED <u>July 21/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 23 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Ever Green Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Chester Ill</u>					
DATE REC'D BY LOCAL REG <u>July 21 1954</u>		REGISTRAR'S SIGNATURE <u>Franie H... ..</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Welge Brothers</u>		ADDRESS <u>Chester Ill</u>					

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

AUG 23 1953

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.....
Signature of Student Embalmer

Signed *Arthur C. Paine*.....

Licensed Embalmer No. *311*.....

P. O. Address *St. Charles*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.