

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 20 1954

State File No. **29186**
Registrar's No. **6417**

BIRTH NO. **67109-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Webster Groves	
c. LENGTH OF STAY (in this place) 2 1/2 hrs		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 St. Louis Childrens			
e. STREET ADDRESS (If rural, give location) 109 Willis Ave			

3. NAME OF DECEASED (Type or Print) a. (First) Denise b. (Middle) Vonne c. (Last) Rhodes			4. DATE OF DEATH (Month) (Day) (Year) 7-13-54		
5. SEX Female		6. COLOR OR RACE negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	
8. DATE OF BIRTH Aug 2, 1953		9. AGE (In years last birthday) -		IF UNDER 1 YEAR: Months 11 Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) St. Louis County	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Harvey Joseph Rhodes		13b. MOTHER'S MAIDEN NAME Willisia Rhodes		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME J. Johnston ADDRESS 500 S. King Highway	

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) Heat exhaustion		II. OTHER SIGNIFICANT CONDITIONS		DUE TO (b) Heat exhaustion	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Heat exhaustion		DUE TO (d) Heat exhaustion	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 35 E 9317	

22. I hereby certify that I attended the deceased from **7-13-1954**, to **7-13-1954**, that I last saw the deceased alive on **7-13-1954** and that death occurred at **8 p. m.**, from the causes and on the date stated above. **46**

23a. SIGNATURE Wm. Klingberg MD (Degree or title)		23b. ADDRESS 500 S. King Highway		23c. DATE SIGNED 7/14/54	
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE 7/16/54		24c. NAME OF CEMETERY OR CREMATORY Father Dickson	
24d. LOCATION (City, town, or county) (State) St. Louis Co Mo		25. FUNERAL DIRECTOR'S SIGNATURE Jessie C Lewis		ADDRESS 22 E. Evelyn	
DATE REC'D BY LOCAL REG. JUL 15 1954		REGISTRAR'S SIGNATURE J. Carl Smith MD			

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.....
Signature of Student Embalmer

Signed *James A. Carter*

Licensed Embalmer No. *460*

P. O. Address *St. Louis*

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.