

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29824**
4017

FILED SEP 28 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 002 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) Kansas City	c. LENGTH OF STAY (In this place) 1 Yr	c. CITY OR TOWN Kansas City	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 (If not in hospital or institution, give street address or location) Lakeside Hospital			
5 th STREET ADDRESS		(If rural, give location) 3229 Paseo	

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) LESLIE c. (Last) RHUDAY			4. DATE OF DEATH (Month) (Day) (Year) Sept 13 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 25, 1870		9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Albany, Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Francis G. Rhuday		13b. MOTHER'S MAIDEN NAME Missouri Ann		14. NAME OF HUSBAND OR WIFE Emma Rhuday	
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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. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Gladys Kail, 3229 Paseo			
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 4 days.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertension - Arterial	4 years		
		DUE TO (c) Arteriosclerosis	10 years.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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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?	

22. I hereby certify that I attended the deceased from Nov 3, 1950 to Sept. 13, 1955 that I last saw the deceased alive on Sept. 13, 1955, and that death occurred at 5:55 p.m., from the causes and on the date stated above.

23. SIGNATURE (Degree or title) <i>Chas. G. Stephens</i>		23b. ADDRESS 3-5-39th Kansas City, Mo.	23c. DATE SIGNED Sept. 14, 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9/14/1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Albany, Missouri	
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DATE REC'D BY LOCAL REG 9-14-55	REGISTRAR'S SIGNATURE <i>Neve Marshall</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stine & McClure Und. Co K.C. Missouri		
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Chas. G. Stephens

Mr. Char. Stephens
will come too,

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 Elmo A. Tjeld.....

Licensed Embalmer No. 481.....

P. O. Address Kansas City,.....

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.