

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

138555

STATE FILE NUMBER

FILED APR 23 1957

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 224

1. PLACE OF DEATH a. COUNTY <u>LINN</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINN</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARCELINE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>BROOKFIELD</u> <u>0580</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. FRANCIS Hosp.</u>			Length of stay in lb <u>15 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>RFD No. 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>ALICE L. RHOADS</u> First Middle Last				4. DATE OF DEATH <u>APR. 20, 1957</u> Month Day Year					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 9, 1878</u>		9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months Days Hours Min.	
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>OWN HOME</u>		11. BIRTHPLACE (City and state or country) <u>RAYTOWN, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>EDWIN DAWSON</u>				14. MOTHER'S MAIDEN NAME <u>BELLE BUSH</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 <u>DR. MARK H. RHOADS, BROOKFIELD, Mo</u> Address <u>RFD. 1</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism and thrombosis</u> DUE TO (b) <u>Interruption cardiac thrombosis</u> DUE TO (c) <u>Aneurysm fibrillation of coronary artery</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Phlebotrombosis rt leg - Rt bundle branch block</u>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4201</u>						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE	
21. I attended the deceased from <u>4-5-57</u> to <u>4-20-57</u> and last saw her/him alive on <u>4-19-57</u> Death occurred at <u>3:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John R. Wilson M.D.</u> (Degree or title)					22b. ADDRESS <u>Brookfield, Mo</u>			22c. DATE SIGNED <u>4-20-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APR. 22, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM</u>			23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, Mo</u>		
24. FUNERAL DIRECTOR <u>WRIGHT FUNERAL HOME, BROOKFIELD, Mo</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>4-21-57</u>		26. REGISTRAR'S SIGNATURE <u>Brookie Owens</u>			

MEDICAL CERTIFICATION

-USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Securing the medical certification in the specific manner required by the laws of Missouri is the responsibility of the registrars.

Health, & Welfare
Public Service

S. 300
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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 *Harold B. Wright*

Licensed Embalmer No. *371*

P. O. Address *Brookfield*

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.