Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-009055
STATE FILE NUMBER

FILED APR 9 1958 Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 315

1. PLACE OF DEATH a. COUNTY Butler b. CITY OR TOWN Poplar Bluff — Inside Limits Yes [X] No [ ] c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Lucy Lee Hosp. — Length of stay in Hospital 2 wks	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Clay c. CITY OR TOWN Corning 8030 — Inside Limits Yes [X] No [ ] d. STREET ADDRESS (If outside, give location) 1st St. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
JOHN	M.	RHEA	3 - 26 - 1958

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	WIDOWED [X]	July 1, 1872	85	8	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
retired merchant		Red Bud, Illinois	U. S. A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Jonathan M. Rhea	Amanda Graves	Minnie Rhea

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		none	Rosalind Kay	Dayton, Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Gastroenteritis -

DUE TO (b) Gen

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) 5711

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

Gen Arteriosclerosis - & congestive failure

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 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 _____, to _____ and last saw her/him alive on _____

Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
John R. Longwell MD	Poplar Bluff, Mo	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
burial	3/29/58	Corning	Corning, Arkansas

24. FUNERAL DIRECTOR	ADDRESS	25. DATE REC'D BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Russell-Ermert	Corning, Ark.	4/5/58	[illegible]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms. All diseases in Part I must be causally related.

RECEIVED
APR 7 1958
BUTLER CO. HEALTH CENTER
FILE No.

JUN 13 1958

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 Richard P. Emmert

Licensed Embalmer No. 782

P. O. Address Corning, A

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.