Health, Welfare Public Service

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FILED MAR 27 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-010721
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 5764 Registrar's No. 11

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Monroe City Warren Twp. — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) R.R. 3 — Length of stay in lb 50 yr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Marion 0640
c. CITY OR TOWN Monroe City — Inside Limits Yes ☐ No ☒ 0
d. STREET ADDRESS (If outside, give location) R.R. 3 — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Alma Middle Last Rhoades

4. DATE OF DEATH Month Feb. Day 19 Year 1958

5. SEX F 1

6. COLOR OR RACE Wh.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐

8. DATE OF BIRTH Feb. 26, 1875

9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months 11 Days 23 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (City and state or country) Hunnewell, Mo 0

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Tompkins

13b. MOTHER'S MAIDEN NAME Ann Boulware

14. NAME OF HUSBAND OR WIFE Henry Rhoades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. none

17. INFORMANT Address Ruby Bleigh, Philadelphia, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral apoplexy	36 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Hypertension	10 yrs.
DUE TO (c)	Nephritis 593X	10 yrs

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 ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 0

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 May 5, 1948, to Feb. 19, 1958 and last saw her/him alive on Feb. 19, 1958
Death occurred at 9:00 a.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. E. Shriver DD. 2

22b. ADDRESS Philadelphia, Mo

22c. DATE SIGNED 2-19-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Feb. 22, 1958

23c. NAME OF CEMETERY OR ~~CREMATORY~~ Philadelphia

23d. LOCATION (City, town, or county) Philadelphia (State) Mo.

24. FUNERAL DIRECTOR Feaster-Garner, ADDRESS Philadelphia, Mo By Lynn S. Feaster

25. DATE RECD. BY LOCAL REG. 2-21-58

26. REGISTRAR'S SIGNATURE Dr. E. M. Lucke By Viola Geer

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

RECEIVED MAR 2 6 1958
MARION CO. HEALTH DEPT.
DATE FILED MAR 2 6 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 Harold Garner

Licensed Embalmer No. 3720

P. O. Address Monrovia Ca

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.