

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039704

FILED VS DEC 14 1959 *28*

STATE FILE NUMBER

Registration District No. *2000* Primary Registration District No. *2000* Registrar's No. *1317*

INDEXED

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b	c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Baptist Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 945 South Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last RHODES			4. DATE OF DEATH Month December Day 4, Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 20 March 1885 74	9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Procure & Groceryman		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and state or country) Georgia		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME C.L. Rhodes		13b. MOTHER'S MAIDEN NAME Sarah Bishop		14. NAME OF HUSBAND OR WIFE Ruth Rhodes	
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. 491-38-5766		17. INFORMANT Address Ruth Rhodes (Wife) Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia					INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Hypertensive Vascular Disease					
DUE TO (c) Anemia secondary to (a)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Epistaxis					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				
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 Dec 1950 , to 12/4/59 and last saw ^{her} him alive on 12/4/59 Death occurred at 11:40 Am on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Effie E. Meelton</i>			22b. ADDRESS 1211 S. Glenstone Springfield, Missouri		22c. DATE SIGNED 12-8-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-7-59	23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri	
24. FUNERAL DIRECTOR ADDRESS KLINGNER MORTUARY, INC. SPRINGFIELD MO.		25. DATE RECD. BY LOCAL REG. 12-8-59	26. REGISTRAR'S SIGNATURE <i>Effie E. Meelton</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

99102834

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Glen A Williams

Licensed Embalmer No. 4651

P. O. Address Springfield

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.