ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

ARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032101
STATE FILE NUMBER

Registration District No. 389 Primary Registration District No. 5173 Registrar's No. 15

FILED OCT 13 1961

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Holts Summit — Length of stay in 1b 44 yrs
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 2 mi West — Inside Limits Yes ☐ No ☑

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY Callaway
c. CITY OR TOWN Holts Summit — Inside Limits Yes ☐ No ☑
d. STREET ADDRESS (If outside, give location) 2 mi West — Reside on Farm Yes ☑ No ☐

3. NAME OF DECEASED (Type or print) First Middle Last: Margaret Baker Rhodes

4. DATE OF DEATH Month Day Year: Oct 6 1961

5. SEX: Female
6. COLOR OR RACE: White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-1-1890
9. AGE (last birthday): 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR 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: Home
11. BIRTHPLACE (City and state or country): St. Louis MO
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Frank Dwight
13b. MOTHER'S MAIDEN NAME: Helen Railton
14. NAME OF HUSBAND OR WIFE: Thomas 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.: None
17. INFORMANT Address: T. P. Rhodes Holts Summit MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): General Artero Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: about 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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.)
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 Oct 31-1960, to Oct 5-1961 and last saw her/him alive on Oct 5-1961
Death occurred at 4:50 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Emma Rusk M.D.
22b. ADDRESS: New Bloomfield Mo
22c. DATE SIGNED: Oct 7-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct 8-1961
23c. NAME OF CEMETERY OR CREMATORY: Union Hill Ceme
23d. LOCATION (City, town, or county) (State): Holts Summit MO

24. FUNERAL DIRECTOR ADDRESS: Claypool Ser. New Bloomfield MO
25. DATE RECD. BY LOCAL REG.: Oct 7-1961
26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

MAY 29 1962

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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield Mo

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.