SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-037510

STATE FILE NUMBER

TMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 169 Primary Registration District No. _____ Registrar's No. 34

FILED OCT 30 1961

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

1. PLACE OF DEATH
a. COUNTY: Knox
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Edina
Length of stay in 1b: 8 da
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Gibson Hospital
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: Knox
c. CITY OR TOWN: Baring
Inside Limits: Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First FRED Middle HAROLD Last RODEY
4. DATE OF DEATH: Month Oct Day 24 Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. Married [ ] Never Married [X] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 8Nov1897
9. AGE (last birthday): 63
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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Knox County
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Henry John Rodey
13b. MOTHER'S MAIDEN NAME: Mary Julia Schultz
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of servic
17. INFORMANT: Mr Glen Scott Address: Brashear, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line f
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Circulatory Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Thrombosis c̄ Myocardial Infarction
DUE TO (c) Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
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. 15, 1961 to Oct. 23, 1961 and last saw him alive on Oct. 23, 1961
Death occurred at 7.05 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. W. Gibson, D.D.
22b. ADDRESS: Edina, Mo.
22c. DATE SIGNED: 10-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 25Oct1961
23c. NAME OF CEMETERY OR CREMATORY: St. Aloysius ~~Church~~
23d. LOCATION (City, town, or county) (State): Baring, Mo

24. FUNERAL DIRECTOR: HUDSON-RIMER FUNERAL HOME ADDRESS: Edina, Mo
25. DATE RECD. BY LOCAL REG.: 10-25-1961
26. REGISTRAR'S SIGNATURE: Nell S. Hunsell

(Licensed Embalmer's Statement on Reverse Side)

Burial permit requested.

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 A G Rimer

Licensed Embalmer No. 5041

P. O. Address Edina, 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.