

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035105

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 458

FILED SEP 27 1962

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b>		c. CITY OR TOWN <b>INDEPENDENCE</b>	
Length of stay in 1b <b>8 YEARS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3350 STERLING</b>		d. STREET ADDRESS (If outside, give location) <b>3350 STERLING</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
<b>ADELE CATHERINE RHODES</b>			Month <b>SEPTEMBER</b> Day <b>23rd</b> Year <b>1962</b>			

5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/6/83</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
-------------------------	--------------------------------------	---	------------------------------------	-------------------------------------	---------------------------	------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (City and state or country) <b>BATES COUNTY, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
---	--	--	--

13a. FATHER'S NAME <b>GEORGE T. DUNCAN</b>	13b. MOTHER'S MAIDEN NAME <b>ELLEN BROWN</b>	14. NAME OF HUSBAND OR WIFE <b>THOMAS NEWTON RHODES</b>
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>PAUL F. RHODES</b>	Address <b>3350 STERLING INDEPENDENCE, MO.</b>
---	--	--	---

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) <b>Myocardial Degeneration</b>		<b>4 mo.</b>
DUE TO (b) <b>Coronary atherosclerosis</b>		<b>4 mo.</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) <b>Bronchial asthma</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	--	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <b>Sept 1, 1961</b> to <b>Sept 23, 1962</b> and last saw her <sup>him</sup> alive on <b>Sept 21, 1962</b> Death occurred at <b>4.00 A.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE <b>John K. Caldwell MD</b> (Degree or title)	22b. ADDRESS <b>306 E 12 St Kansas City, Mo.</b>	22c. DATE SIGNED <b>9/24/62</b>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>SEPT. 25, '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
---	-----------------------------------	--	--

24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons, Kansas City, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>9-25-62</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

17005  
29005

3

4 1

5 2

6

7 0

8 0

9420.1

10

11

1290-0

13 1-0

OCT 4 1962

Dr. John H. Caldwell  
1036 Angler Bldg.  
2:30 - 5:30

9-25-62

**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 *V. Faerber*

Licensed Embalmer No. 4915  
P. O. Address KC 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.