No. 2
I—2-43
5-17-39
I X35697

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

42245

FILED JAN 9 1946

State File No. 17

Registration District No. 298 Primary Registration District No. 6024 Registrar's No.

1. PLACE OF DEATH:
(a) County Clinton Ray
(b) City or town Lawson Rural (Tol
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Clay 89
(c) City, or town Lawson Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MARY ELIZABETH RHODES
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 11 (Day) 1864 (Year)

8. AGE: Years 81 Months 10 Days 29 If less than one day hr. min.

9. Birthplace Clinton Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name Daniel Cook
13. Birthplace (City, town, or county) Virginia (State or foreign country)
14. Maiden name Brooks
15. Birthplace (City, town, or county) Indiana (State or foreign country)
16. (a) Informant Iva Rhodes
(b) Address Lathrop, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 '45 (Month) (Day) (Year)
(c) Place: burial or cremation Lawson Cemetery
18. (a) Signature of funeral director Jarman-Pinchard
(b) Address Lathrop Missouri
19. (a) 12-11-45 (Date received local registrar) (b) W Reed (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 10
year 1945 hour 11 minute A M.
21. I hereby certify that I attended the deceased from Dec 1, 1945 to Dec. 10, 1945
that I last saw her alive on Dec. 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure & Pulmonary Edema — Duration
Due to Carcinoma of Descending Colon & Ascites
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Petrus C Burkhart (M. D. or other)
Address Lawson Date signed 12-11-45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-8-46

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed, Claude Pinchard

Licensed Embalmer No. 2751

P. O. Address Excelsior Springs, 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 this body is not embalmed, fact should be so stated above.

S. No. 2B
3M—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 298 | Primary Registration District No. 6024 | Registrar's No. 17

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary E. Rhodes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 11, 1864
(Month) (Day) (Year)

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeping for home until last illness

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace
(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) W. A. Black (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day
year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

42245