

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28403
Registrar's No. 1500

FILED SEP 7 1948

Registration District No. 317

Primary Registration District No. 3066

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Kirkwood 22 Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
435 N. Kirkwood Rd
(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)

3. (a) PRINT FULL NAME Ida Frances Rutledge

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife W. E. Rutledge 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased September 15 1864
(Month) (Day) (Year)

8. AGE: Years 83 Months 10 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Tenn. 1 (State or foreign country)

10. Usual occupation Nil

11. Industry or business _____

MOTHER FATHER { 12. Name Heathcock
13. Birthplace Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Lula R. Piercy
(b) Address 435 N. Kirkwood Rd Kirkwood Mo
17. (a) Burial (b) Date thereof 8/17/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery
18. (a) Signature of funeral director Meger-Pfizinger
(b) Address Kirkwood 22 Mo

19. (a) 8-17-48 (b) Cecil A. Shroy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 9 1/2
(c) City or town Kirkwood 22
(If outside city or town limits, write "RURAL") 3
(d) Street No. 435 N. Kirkwood Rd
(If rural, give location) D
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14
year 1948 hour 5 minute P M.

21. I hereby certify that I attended the deceased from 8/12, 1948, to 8/17, 1948;
that I last saw her alive on 8/17, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration 2 1/2
Hypertensive cardio-vascular renal disease
Due to _____
Due to 93-10

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? _____

While at work? _____ (Specify type of place) (c) Means of injury 1

23. Signature J. D. Stealye (M. D. or other M.D.)
Address 104 W. Adams, Berkeley Date signed 8/16/48

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

300
10-47
17-39
1 3908

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 John M. Meyer

Licensed Embalmer No. 3288

P. O. Address Kirkwood, 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.

2B
45
43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 1942

Registration District No. 317

Primary Registration District No. 3066

1. PLACE OF DEATH:

(a) County ST. LOUIS
(b) City or town Kirkwood
(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 _____ (Specify whether _____)
years, months or days

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

Ida F. Rutledge

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 _____

7. Birth date of deceased _____

Sept 15
(Month) (Day) (Year)

8. AGE:

Years 83

Months _____

Days _____

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country) Ill

10. Usual occupation _____

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 _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-17-48

(Date received local registrar)

(b) Bevil A. Shapley

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year 1948 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

28403