

THE DIVISION OF HEALTH OF MISSOURI
FILED MAY 25 1956 STANDARD CERTIFICATE OF DEATH

State File No. **18571**
Registrar's No. **4655**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE Missouri - b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis mo		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 2 days		e. STREET ADDRESS (If rural, give location) 5 5738 Enright 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) Edward	b. (Middle) A	c. (Last) Rutledge	4. DATE OF DEATH (Month) (Day) (Year) 5-12-56
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 28, 1883	9. AGE (In years last birthday) 72yrs.	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 MRS. Hours _____	IF UNDER 1 MRS. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician, Dept. City of St. Louis	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Robert Rutledge	13b. MOTHER'S MAIDEN NAME Cowden	14. NAME OF HUSBAND OR WIFE Ruth Stillman Rutledge
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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. 488-09-1207	17. INFORMANT'S SIGNATURE OR NAME Mrs. Elizabeth Killion	ADDRESS 5814 Cabanne
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia, right upper lobe, with meningitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pneumo-co-coccal DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aneurysm of abdominal aorta		Diagnosed Jan., 1956	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 490x	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **5-11**, 1956, to **5-12**, 1956, that I last saw the deceased alive on **5-12**, 1956, and that death occurred at **10:45 pm.**, from the causes and on the date stated above.

23a. SIGNATURE FR Bradley	(Degree or title) M. D. C.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 5/13/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 15, 1956	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAY 14 1956	REGISTRAR'S SIGNATURE _____	25. FUNERAL DIRECTOR'S SIGNATURE G. J. Glander & Sons 6175 Delmar	ADDRESS _____
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m J B (Licensed Embalmer's Statement on Reverse Side)

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

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 *Jos. E. McCulloch*

Licensed Embalmer No. *246*

P. O. Address *6175 Del*

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.