

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**19537**  
STATE FILE NUMBER

FILED JUN 22 1956

Registration District No. 27 Primary Registration District No. 3005 Registrar's No. 89

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Bates</u>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>                 |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Butler</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |                               | c. CITY OR TOWN <u>Butler</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Butler Memorial Hosp.</u> Length of stay in lb <u>2.8 days</u>   |                               | d. STREET ADDRESS (If outside, give location) <u>107 S. Delaware</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Myrtle</u> Last <u>Rook</u>   |                               |  | 4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1956</u>                              |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-15-1893</u>  |
| 9. AGE (In years last birthday) <u>62</u>   |                               | 10. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>   | 11. BIRTHPLACE (City and state or country) <u>Ft. Madison, Iowa</u>                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Albert Seese</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Lula Wade</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>488 36 2520</u>   |  |
|   |                               | 17. INFORMANT <u>Clyde Rook</u> Address <u>Butler, Mo.</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma, stomach</u><br>DUE TO (b) <u>with metastases.</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                               |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>Name</u>   |  |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. <u>Name</u>   |                               |  |  |
| 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 <u>July, 1955</u> to <u>6/13/56</u> and last saw her/him alive on <u>6/13/56</u> . Death occurred at <u>6/13/56</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |                               |  |  |
| 22a. SIGNATURE (Degree or title) <u>Ronald</u>  |                               | 22b. ADDRESS <u>Butler, Mo.</u>  |  |
|   |                               | 22c. DATE SIGNED <u>6/14/56</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE <u>6-15-56</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Oakhill Cemetery</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>Butler, Mo.</u>   |  |
| 24. FUNERAL DIRECTOR <u>John G. Underwood</u> ADDRESS <u>Butler, Mo.</u>  |                               | 25. DATE RECD. BY LOCAL REG. <u>June 14-56</u>   |  |
|   |                               | 26. REGISTRAR'S SIGNATURE <u>Ronald</u>  |  |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Caroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert G. Steinbeck*  
Licensed Embalmer No.....<sup>40</sup>

P. O. Address *Butte*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.