

Dept. Health,
& Welfare
S. Public
Health Service

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

407223
STATE FILE NUMBER
Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 496

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Aurora Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 808 So. Forest		Length of stay in 1b 1 yr.	d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Ruddick			4. DATE OF DEATH Month Nov. Day 15, Year 1957		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1872	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) St. Louis Co., Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Jas. Franklin Flowers	13b. MOTHER'S MAIDEN NAME Verlenia Rogers	14. NAME OF HUSBAND OR WIFE Robert C. Ruddick
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Lloyd Reese, 808 So. Forest, Indep., Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>6 yrs</u> <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	
	DUE TO (c) <u>Cerebral Thrombosis</u> 332X	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Glomerulonephritis</u>		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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____	

20d. INJURY OCCURRED WHILE AT <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 Aurora, Missouri	COUNTY _____ STATE _____
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21. I attended the deceased from Nov 1956 to Nov 15 1957 and last saw her alive on Nov 15, 1957
Death occurred at 6:22 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. H. Horsch MD</u> (Degree or title)	22b. ADDRESS <u>10901 Winner Rd E. Independence, Mo</u>	22c. DATE SIGNED <u>Nov 17, 1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 15, 1957.	23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery	23d. LOCATION (City, town, or county) Aurora, Missouri	(State) _____
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24. FUNERAL DIRECTOR George C. Carson, Independence, Mo.	ADDRESS _____	25. DATE RECD. BY LOCAL REG. 11-15-57	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

540

NOV 27 1967

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 *Everett H. Smith*

Licensed Embalmer No. *5001*

P. O. Address *K. C. 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.