

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046864

STATE FILE NUMBER

*7140*  
FILED DEC 16 1958

Registration District No. 322 Primary Registration District No. 3071 Registrar's No. 45

999  
S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Slater</u> <u>0972</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>425 E. Parker</u>		Length of stay in 1b <u>6 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>425 E. Parker</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Emily</u> Last <u>Steding</u>			4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1958</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1866</u>	9. AGE (In years last birthday) <u>92</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Glasgow, Missouri.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Phillip Ruffel</u>	13b. MOTHER'S MAIDEN NAME <u>Teresa Baier</u>	14. NAME OF HUSBAND OR WIFE <del>Deceased</del> <u>Harold R.</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give dates of service))	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mildred Caldwell Slater, Mo.</u> Address
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18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. myocarditis &amp; failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year 2 wks. 2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized arteriosclerosis</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	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	COUNTY	STATE
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21. I attended the deceased from <u>April 1949</u> to <u>Dec. 12, 1958</u> and last saw her alive on <u>12-11-58</u> Death occurred at <u>3:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>C. A. McBurney, M.D.</u> (Degree or title)	22b. ADDRESS <u>Slater, Mo.</u>	22c. DATE SIGNED <u>12-12-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Slater, Missouri.</u>
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24. FUNERAL DIRECTOR <u>Haines Funeral Home Slater, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-13-58</u>	26. REGISTRAR'S SIGNATURE <u>Mo. Earl C. Metz</u>
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(Licensed Embalmer's Statement on Reverse Side)

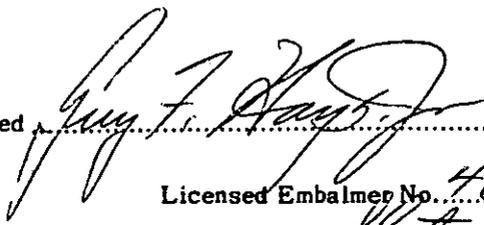
C.A. McBurney  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
No symptoms will be listed.

MEDICAL CERTIFICATION

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  .....,  
Licensed Embalmer No. 4630  
P. O. Address Water 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.