Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 13 1959

59-008087
STATE FILE NUMBER

Registration District No. 233 Primary Registration District No. 3074 Registrar's No. 42

1. PLACE OF DEATH
a. COUNTY: Scott
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Sikeston — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Mo. Delta Comm. Hosp. — Length of stay in 1b: 4 Hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Scott
c. CITY OR TOWN: Sikeston 100 3 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 329 Westgate St. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: ROBERT Middle: EDWARD Last: RUFFIN

4. DATE OF DEATH Month: 2 Day: 24 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-5-1944

9. AGE (In years on last birthday): 14 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Caruthersville, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Carl Lee Ruffin

13b. MOTHER'S MAIDEN NAME: Vesta Crayton

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Carl L. Ruffin, Address: Sikeston, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 12-15 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Unknown
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hydrocephalus C534

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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 WORK ☐ NOT WHILE AT WORK ☐

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 9:30 2-23-59 to 4:55 2-24-59 and last saw her/him alive on 2/24/59
Death occurred at 4:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Thomas Walters, M.D.

22b. ADDRESS: Sikeston, Mo.

22c. DATE SIGNED: Mar. 3, '59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-1-59

23c. NAME OF CEMETERY OR CREMATORY: Smith West End Cemetery

23d. LOCATION (City, town, or county) (State): West of Sikeston Mo.

24. FUNERAL DIRECTOR: Fred L. Smith Sikeston Mo. 1212 Maud

25. DATE REC'D BY LOCAL REG.: 3-7-59

26. REGISTRAR'S SIGNATURE: Mrs. Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

Doctor, Coroner, etc. must use only blacked ink or ribbon typewriter. No symbols or numbers. All diseases in Part I must be causally related.

VS NOV 1 2

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 Fred J. Smith

Licensed Embalmer No. 4408

P. O. Address Sikeston 7

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.