

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028161

FILED VS SEP 14 1959 35

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 423

STATE FILE NUMBER

|   |   |   |  |  |  |  |  |
|---|---|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u> |  |  |  |
| b. CITY (if outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Columbia</u>  |   | Length of stay in 1b<br><u>39 days</u>  |  | c. CITY OR TOWN <u>Waynesville</u>   |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>University Medical Center</u>   |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location)<br><u>Route 2</u>  |  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <u>James</u> Middle <u>Eliga</u> Last <u>Rutledge</u>  |   |   |  | 4. DATE OF DEATH<br>Month <u>Sept.</u> Day <u>7</u> Year <u>1959</u>   |  |  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-22-95</u>   | 9. AGE (last birthday)<br><u>64</u>  | IF UNDER 1 YEAR<br>Months _____ Days _____   | IF UNDER 24 HR<br>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 of country)<br><u>Mississippi</u>   |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S.</u>                                |
| 13a. FATHER'S NAME<br><u>Edmond Rutledge</u>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>Florence Greenlee</u>                                |  | 14. NAME OF HUSBAND OR WIFE<br><u>Wanda Rutledge</u>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO.<br><u>348-05-2746</u>   |  | 17. INFORMANT<br>Address _____   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>acute renal failure</u>  |   |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 days</u>                          |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>septicemia</u>  |   |  |  |  |  |  |
|   | DUE TO (c) <u>subdiaphragmatic abscess</u>  |   |  |  |  |  | <u>15 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Diverticulitis &amp; sigmoidovesical fistula; erosive gastritis with acute hemorrhages and subtotal gastrectomy</u> |   |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |   |   |  |  |  |  |  |
| 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>30 July 59</u> to <u>7 Sept 59</u> and last saw <u>him</u> alive on <u>7 Sept 59</u><br>Death occurred at <u>2:10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.             |   |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>J. L. Elli, M.D.</u> (Degree or title)   |   |   |  | 22b. ADDRESS<br><u>U. of Missouri Medical Center</u>   |  | 22c. DATE SIGNED<br><u>7 Sept 59</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>Sept 9, 1959</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rolla Cemetery</u>   |  | 23d. LOCATION (City, town, or county)<br><u>Rolla, Missouri</u>  |  | 23e. STATE<br><u>Missouri</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>Carl Glenn</u> ADDRESS <u>Rolla, Mo</u>  |   |   | 25. DATE REC'D. BY LOCAL REG.<br><u>Sept 7 1959</u>                                  |  | 26. REGISTRAR'S SIGNATURE<br><u>Mrs. R.E. Palmer</u>   |  |  |

DEED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 15 1980

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed George R. Leamm

Licensed Embalmer No. 4425

P. O. Address Columbia

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