

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038939

FILED VS DEC 8 1959

38

Primary Registration District No. 3006 Registrar's No. 591

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>34 days</u>		c. CITY OR TOWN <u>Waynesville</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Med. Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Chimney Tailer Ct.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Wanda</u> Middle <u>Maxine</u> Last <u>Rutledge</u>			4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1959</u>				
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>7-10-1919</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Reynoldsville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Clifford Headrick</u>			13b. MOTHER'S MAIDEN NAME <u>Beulah Fulford</u>		14. NAME OF HUSBAND OR WIFE <u>James Rutledge</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. _____		17. INFORMANT Address <u>Hospital chart</u>			
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>Cerebral anoxia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Respiratory insufficiency</u>					<u>2 yrs.</u>
		DUE TO (c) <u>Pulmonary fibrosis, idiopathic</u>					<u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>11-28-59</u> to <u>11-29-59</u> and last saw <sup>her</sup> him <u>live</u> on <u>11-29-59</u> Death occurred at <u>12<sup>00</sup></u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J.M. Mort M.D.</u>				22b. ADDRESS <u>U. of Mo. Med. Ctr., Columbia, Mo.</u>			22c. DATE SIGNED <u>11/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-2-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rolla Cem.</u>		23d. LOCATION (City, town or county) <u>Waynesville, Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Spradle, Columbia</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 30 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 15 1960

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

by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed George R. Stamm

Licensed Embalmer No. 4425

P. O. Address \_\_\_\_\_

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.