

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045531

FILED VS DEC 2 0 1960

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 427 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cole</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jefferson City</u>		Length of stay in 1b <u>20 hrs.</u>	c. CITY OR TOWN <u>Jefferson City</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>Chas. E. Still</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>513 Jefferson St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Jessie Lucille Rucker</u>			4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days 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) <u>Jackson Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>James Stillwell</u>		13b. MOTHER'S MAIDEN NAME <u>Garrison</u>		14. NAME OF HUSBAND OR WIFE <u>Garvin Rucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Garvin Rucker, 313 Jefferson</u> Address	
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>medullary failure</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Arteriosclerotic heart disease</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 type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH
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 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>Nov 5, 1960</u> to <u>Dec 11, 1960</u> and last saw her alive on <u>Dec 11, 1960</u> Death occurred at <u>1:50 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Carl B. Craig MD</u>			22b. ADDRESS <u>303. W. M. County Jefferson City</u>		22c. DATE SIGNED <u>12-11-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-13-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CARRSVILLE</u>		23d. LOCATION (City, town, or county) (State) <u>Blairstown Mo</u>
24. FUNERAL DIRECTOR <u>SICKMAN & DUNNING</u>		ADDRESS <u>Clinton</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 16 1960</u>	26. REGISTRAR'S SIGNATURE <u>R.P. Harris, M.D. N. Richter, R.P.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 7 1963

VS JAN 16 1961
OCT 18 1962

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 Robert L. Dunn

Licensed Embalmer No. 471

P. O. Address Clinton

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.