

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-047892

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3694

STATE FILE NUMBER

AMENDED

FILED JAN 19 1962

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>    </u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KOCH MO</u>		Length of stay in 1b <u>256 days</u>	c. CITY OR TOWN <u>ST LOUIS</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ROBT KOCH HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3446 EADS</u>		
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>B.</u> Last <u>RUDDICK</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1961</u>		
5. SEX <u>MALE</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>Dec 9-1898</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOUNDRY</u>	11. BIRTHPLACE (City and state or country) <u>HUNTSVILLE ALA</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOSEPH RUDDICK</u>		13b. MOTHER'S MAIDEN NAME <u>M. LANDIS</u>		14. NAME OF HUSBAND OR WIFE <u>ETHEL HUBBARD RUDDICK</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. <u>    </u>	17. INFORMANT Address <u>HOSPITAL RECORD - KOCH HOSPITAL</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>CHRONIC PULMONARY EMPHYSEMA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>years?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
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	
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>April 13/61</u> to <u>Dec 25/61</u> and last saw him alive on <u>Dec 24, 1961</u> Death occurred at <u>1555 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Frank Colson MD</u>			22b. ADDRESS <u>Robert Koch Hospital KOCH MO</u>		22c. DATE SIGNED <u>12/25/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		(State)
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>			25. DATE RECD. BY LOCAL REG. <u>12-26-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

**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 W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis 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.