No. 2
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17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 13 1948
Registration District No. 128

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 19207
Registrar's No. 559

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Medical Arts Bldg. 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution One Week (Specify whether
In this community One Week
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Webster 112
(c) City or town ~~Rural~~ Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME Kenneth Lee Rudolph
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Single 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February (Month) 20 (Day) 1947 (Year)

8. AGE: Years 1 Months 4 Days 17 If less than one day hr. min.

9. Birthplace Springfield, Greene Co., Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation Child
11. Industry or business
FATHER
12. Name Walter Rudolph
13. Birthplace Mo. 0
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Vesta Keller
15. Birthplace Mo. 0
(City, town, or county) (State or foreign country)
16. (a) Informant Vesta Rudolph
(b) Address Diggins, Mo.
17. (a) Removal (b) Date thereof 7-9-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Diggins, Mo.
18. (a) Signature of funeral director Kelly, Ferrell, Bergman
(b) Address Seymour, Mo.
19. (a) 7-9-48 (b) W. E. Hardley MD
(Date received local registrar) (Registrar's signature) 111

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 7 day 7
year 1948 hour 3 minute 30 P M.
21. I hereby certify that I attended the deceased from 6-26-48
, 19, to 7-7, 1948
that I last saw him alive on 7-7- 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Suffocation	
Due to Foreign body	6 wk
Due to	
Other conditions Bronchopneumonia (Include pregnancy within 3 months of death)	1 wk
Atelectasis	
Major findings: Of operations 195	
19	
Of autopsy Foreign body Bronchopneumonia atelectasis	

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

23. Signature [illegible] (M. D. or other)
Address Springfield Mo Date signed 7-7-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed J. B. Klingner

Licensed Embalmer No. 3358

P. O. Address Springfield Me

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 this body is not embalmed, fact should be so stated above.

No. 2B
—3-45
I X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 559

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kenneth L. Rudolph

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 20 1944
(Month) (Day) (Year)

8. AGE: Years 1 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Bean in throat

(b) Date of occurrence About May 25 - not known exactly

(c) Where did injury occur? Diggins, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home.
(Specify type of place)

While at work? (e) Means of injury

23. Signature Lutie Burch (M. D. or other)

Address Date signed

SUPPLEMENTARY

1945
19

S-19207