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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3206

FILED FEB 2 1949

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

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No. 808			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Adair					
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place) 3 weeks		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis Mo		13			
d. FULL NAME OF HOSPITAL OR INSTITUTION Horner & Phillips				d. STREET ADDRESS (If rural, give location) 2210 Chestnut					
3. NAME OF DECEASED (Type or Print) Tom		a. (First)		b. (Middle) Rutledge		4. DATE OF DEATH (Month) (Day) (Year) Jan. 23 1949			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Mar. 27, 1993			
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Pontiac Mass		12. CITIZEN OF WHAT COUNTRY? U.S.A			
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Ben Rutledge		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mabel Rutledge		ADDRESS 2210 Chestnut			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION with Ulcers I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pott's Disease of 3rd Cervical Vertebrae  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pott's Disease of right Sacro iliac Region DUE TO (c) Undetermined  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH  16.20	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 10-29-1948, to 1-23-1949, that I last saw the deceased alive on 1-23-1949, and that death occurred at 9:25 a.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Charles R. Foster M. D. (1)				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 1-24-49			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Jan. 28, 1949		24c. NAME OF CEMETERY OR CREMATORY Washington P.R.		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. JAN 27 1949		REGISTRAR'S SIGNATURE J.B. Casata		25. FUNERAL DIRECTOR'S SIGNATURE Floyd English		ADDRESS 2931 Lucas Ave			

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Burleson English*

Licensed Embalmer No. \_\_\_\_\_

*4208*

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

*2931 Lucas Ave*

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.