

FILED NOV 26 1951

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **38434**

BIRTH NO. _____ REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5985 Registrar's No. 163

1. PLACE OF DEATH a. COUNTY Pulaski		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE West Virginia b. COUNTY Harrison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fort Leonard Wood, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clarksburg	
d. FULL NAME OF HOSPITAL OR INSTITUTION US Army Hospital		d. STREET ADDRESS (If rural, give location) 124 Fynn Street	
3. NAME OF DECEASED (Type or Print) a. (First) Ruellen		b. (Middle) Irene	
c. (Last) Mapes		4. DATE OF DEATH (Month) (Day) (Year) November 15 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1	8. DATE OF BIRTH June 30, 1951
9. AGE (In years last birthday) 4		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____	11. BIRTHPLACE (State or foreign country) 9
10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Charles D. Mapes		13b. MOTHER'S MAIDEN NAME Wanda I. Williams	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: (a) Septicemia, bacterial ANTECEDENT CAUSES DUE TO (b) Adrenal hemorrhage DUE TO (c) Infarct, right lung (supp report) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 491X	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 11 hours	
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 Nov 15 , 19 51 , to Nov 15 , 19 51 , that I last saw the deceased alive on Nov 15 , 19 51 , and that death occurred at 11:10p m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Kenneth C. Nichol, Capt MC		23b. ADDRESS US Army Hosp, Ft. L.W., Mo.	
23c. DATE SIGNED 17 Nov/51		24. NAME OF CEMETERY OR CREMATORY Clarksburg West Va.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Nov 17, 1951	24c. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. 11-19-51	REGISTRAR'S SIGNATURE Eula D. Anderson	25. FUNERAL DIRECTOR'S SIGNATURE Nedger Funeral Home, Mo.	

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

0850

949

RECEIVED 11-19-51
Pulaski County Health Officer
File Number 11-24-51
Date Filed

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. 432
working under my personal supervision.

Student Carene Moss
Student Embalmer

Signed Walter Hedges

Licensed Embalmer No. 4265

P. O. Address Berlin, Md.

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.