

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30389

FILED AUG 20 1953

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>7404</u>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>2199</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) <u>3 Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital # 1</u>				e. STREET ADDRESS (If rural, give location) <u>Savoy Hotel 3900 Olive St.</u>				
3. NAME OF DECEASED a. (First) <u>William</u>			b. (Middle) _____		c. (Last) <u>Rutledge</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 27 1953</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Nov. 12, 1913</u>		9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months _____	IF UNDER 10 HRS. Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>William R. MacCreedy</u>			13b. MOTHER'S MAIDEN NAME <u>May Madison</u>		14. NAME OF HUSBAND OR WIFE <u>Maxine Noll Rutledge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. # 2</u>		16. SOCIAL SECURITY NO. <u>486-20-5617</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Herbert B. MacCreedy Belmont Road Ills.</u> 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>cardiovascular accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>metastatic carcinoma site undetermined</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		199.1		
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 <u>April 30</u> , 19 <u>53</u> , to <u>July 28</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>53</u> , and that death occurred at <u>1:20PM.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>James F. Sullivan</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>1515 Lafayette</u>		23c. DATE SIGNED <u>7/28/53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-31-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>JUL 30 1953</u>		REGISTRAR'S SIGNATURE <u>Charles Smith</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u> ADDRESS <u>3840 Lindell</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

Primary care - supra. Cardiovascular notes

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 *me*..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Wm. S. Lagan*.....  
Licensed Embalmer No. *469*.....  
P. O. Address *M. P. Lagan*.....

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.