

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

31484

State File No.

FILED SEP 20 1954

BIRTH NO. _____ REG. DIST. NO. 293 PRIMARY REG. DIST. NO. 6005- Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Ralls</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Spencer</u>	c. LENGTH OF STAY (in this place) <u>in-transit</u>	c. CITY OR TOWN <u>Louisiana</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>U. S. Highway #61</u>		* STREET ADDRESS (If rural, give location) <u>Rural--RFD, Louisiana, Mo. 08201</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MAYME</u>	b. (Middle) <u>REINEKING</u>	c. (Last) <u>RULE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 29, 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 23, 1887</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Abeline, Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>Charles Reineking</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Anna Goodman</u>	14. NAME OF HUSBAND OR WIFE <u>Jacob Griffin Rule</u>
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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>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Dwight Campbell, Louisiana, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>As the result of an automobile accident</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>	DUE TO (b) <u>by Berly B. Lacy Jr traveling in the left hand lane of traffic attempting to pass an automobile, collided with a chevrolet automobile driven by Jacob Griffin Rule.</u>	DUE TO (c) <u> </u>	
II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>E8164 26</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway #61</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Spencer Ralls Co, Mo.</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>6:29-54 6:30 P.M.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto accident</u>
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22. I hereby certify that I attended the deceased from No Medical Attention, 19 , that I last saw the deceased alive on , 19 , and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Clayton W. Wynn</u> Coroner <u>3</u>	23b. ADDRESS <u>Ralls Co, Perry, Mo.</u>	23c. DATE SIGNED <u>8-24-54.</u>
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24a. BURIAL, CREMATION, REQUIVAL (Specify) <u>Burial</u>	24b. DATE <u>7/2/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Pike Co, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-1954</u>	REGISTRAR'S SIGNATURE <u>Jack Conn</u> <u>4707</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sterne Funeral Home, Louisiana, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

870
3

Sept.

SEP 20 1954

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 *Virginia M. Stern*.....

Licensed Embalmer No...4643

P. O. Address *P. O. Box 1000*

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.