

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1051

STATE FILE NUMBER

FILED JAN 14 1957

Registration District No. 128 Primary Registration District No. 5465 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Greene	
b. CITY OR TOWN Springfield (RURAL, within corporate limits, give TOWNSHIP only) Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunshine Acres		d. STREET ADDRESS 2134 N. Robberson (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b 18 Mo.		3396	

3. NAME OF DECEASED (Type or print) MARY RERUCHA First Middle Last			4. DATE OF DEATH Jan. 5, 1957 Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Feb. 1876		9. AGE (In years last birthday) 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Coufal			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT W. J. Krenk Address Springfield, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 76 hrs. 5 yrs.	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Aug 22 1956 , to 1-5-57 and last saw her alive on 1-4-57 Death occurred at 5:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Paul O. Morton M.D.		22b. ADDRESS 1630 N. Jefferson Springfield, Missouri		22c. DATE SIGNED 1-5-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b. DATE 1-5-57		23c. NAME OF CEMETERY OR CREMATORY Dwight Cemetery	
23d. LOCATION (City, town, or county) (State) Dwight, Nebraska					
24. FUNERAL DIRECTOR J. Klingner & Co.		25. DATE RECD. BY LOCAL REG. 1-8-57		26. REGISTRAR'S SIGNATURE Wm. Williams	
ADDRESS Spgrd. Mo.					

(Licensed Embalmer's Statement on Reverse Side)

alth, welfare, public service

300 -56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in Part 18. No symptoms written on this form.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Ogle Stone Jr.*
.....

Licensed Embalmer No. *41*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.