

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **31113**

BIRTH NO. FILED SEP 20 1957		REG. DIST. NO. 58		PRIMARY REG. DIST. NO. 4082		Registrar's No. 25	
1. PLACE OF DEATH a. COUNTY Carter 080				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Mo b. COUNTY Carter 080			
b. CITY OR TOWN Ellsinore		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Ellsinore		d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒ 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Own Home				e. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First) Rosa		b. (Middle)		c. (Last) Clouse		4. DATE OF DEATH (Month) (Day) (Year) Sept 14 1957	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 10 1881	
9. AGE (In years) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (City and State or Foreign Country) Howel Co. Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Anthony Townsend		13b. MOTHER'S MAIDEN NAME Sarah Epps		14. NAME OF HUSBAND OR WIFE William Clouse		15. WAS DECEASED MEMBER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. —		17. INFORMANT'S SIGNATURE OR NAME N.C. Townsend		18. ADDRESS Van Buren		19. MEDICAL CERTIFICATION	
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Circulatory Failure ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Arterial Hypertension				INTERVAL BETWEEN ONSET AND DEATH 2 days 18 months 8 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X				20. AUTOPSY? YES ☐ NO ☐	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 4-6 , 19 48 , to 9-14 , 19 57 , that I last saw the deceased alive on Sept 13 , 19 57 , and that death occurred at 10:30 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Frank J. Rucinski, D.O.				23b. ADDRESS Van Buren, Mo		23c. DATE SIGNED 9-16-57	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Sept 17-57		24c. NAME OF CEMETERY OR CREMATORY East Wood		24d. LOCATION (City, town, or county) (State) East Wood Mo	
DATE REC'D BY LOCAL REG. Sept 16-57		REGISTRAR'S SIGNATURE Mrs. Ceta Benson		25. FUNERAL DIRECTOR'S SIGNATURE Seaton Peritt		ADDRESS Van Buren	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

SEP 19 1957

CARTER COUNTY
HEALTH CENTER

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 *Seaton Pruitt*.....

Licensed Embalmer No. *2287*

P. O. Address *Van Buren*

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.