

Health,
Welfare
Public
Service

FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005822
STATE FILE NUMBER
420

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 420

800
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Town Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) General Hosp. No. 1		STREET ADDRESS (If outside, give location) 1014 West 16th Terrace	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in hospital 12 days		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle M Last Ruddicks Jr.			4. DATE OF DEATH Month January Day 26 Year 1958		
--	--	--	---	--	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-64	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 1 Days 12 Hours 52 Min. 12	IF UNDER 24 HRS. Hours 1 Min. 2
--------------------	-------------------------------	---	---------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (City and state or country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME William M. Ruddicks, Sr.	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Annie Ruddicks
---	---	--

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. none	17. INFORMATION James S. Ruddicks 5212 Security Medical Records, General Hosp. No. 1
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Dehydration and malnutrition		???
DUE TO (c) _____		490X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 24th and Cherry	COUNTY _____ STATE _____
--	--	--	--------------------------

21. I attended the deceased from 1-25-58 to 1-26-58 and last saw her alive on 1-26-58 Death occurred at 6:24 A m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>[Signature]</i> (Degree or title) D.O.	22b. ADDRESS 24th and Cherry	22c. DATE SIGNED 1-26-58
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-26-58	23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Mo.	23d. LOCATION (City, town, or county) (State) Pleasant Hill, Mo.
---	-----------------------------	--	--

24. FUNERAL DIRECTOR Gravesill-Stanley	ADDRESS Pleasant Hill Mo.	25. DATE RECD. BY LOCAL REG. 1-26-58	26. REGISTRAR'S SIGNATURE neva minshall
--	-------------------------------------	--	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

I. B U I T S



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 *John R. Deid*

Licensed Embalmer No. *453*
P. O. Address *.....*

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.