

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-025256

STATE FILE NUMBER

FILED AUG 6 1958

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 846

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Henry	
b. CITY (If outside corporate limits, give TOWN or TOWN) Clinton		c. CITY OR TOWN Clinton 0422	
c. FULL NAME OF (If NOT in hospital, give location) Hospital OR INSITUATION Missouri Rest Home		d. STREET ADDRESS (If outside, give location) 901 1/2 Second	
3. NAME OF DECEASED First Middle Last WILLIAM 7 CRUISE		4. DATE OF DEATH Month Day Year July 29 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1919
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		9b. KIND OF BUSINESS OR INDUSTRY none	
10a. BIRTHPLACE (City and state or country) North View Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joseph Cruise		13b. MOTHER'S MAIDEN NAME Nora B Messier	
14. NAME OF HUSBAND OR WIFE			
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. ?	
17. INFORMANT		Address Missouri Rest Home Records Clinton 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) Chronic myocarditis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Muscular dystrophy DUE TO (c) 7441 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none			INTERVAL BETWEEN ONSET AND DEATH 5 months 3 years
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 2/18/56 to 7/29/58 and last saw him alive on 7/6/58 Death occurred at 3 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE S. B. Hughes (Degree or title) M.D. C		22b. ADDRESS Clinton Mo.	
22c. DATE SIGNED 7/30/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Reinterment		23b. DATE 7-31-58	
23c. NAME OF CEMETERY OR CREMATORY Mt Pleasant		23d. LOCATION (City, town, or county) Springfield Mo.	
24. FUNERAL DIRECTOR SCHABERG FUNERAL HOME		25. DATE RECD. BY LOCAL REC 7-31-58	
26. REGISTRAR'S SIGNATURE Mildred Bigum			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 \_\_\_\_\_

Licensed Embalmer No. 4513

P. O. Address... Clinton, W.

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.