

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032017
STATE FILE NUMBER

FILED SEP 24 1958 Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 132

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY OR TOWN <u>Harrisonville</u> (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural Grand River Twp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) <u>Memorial Hospital</u> Length of stay in lb HOSPITAL OR INSTITUTION <u>3 days</u>		d. STREET ADDRESS (If outside, give location) <u>1 mi S of Harrisonville</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>PAYL</u> Middle <u>V</u> Last <u>MUDD</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1958</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25 1899</u>	9. AGE (In years last birthday) <u>63</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock buyer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Bates Co Mo</u>	11. BIRTHPLACE (City and state or country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>J.D. Mudd</u>	13b. MOTHER'S MAIDEN NAME <u>Ruth Cathcart Lucy Mudd</u>	14. NAME OF HUSBAND OR WIFE <u>Andrew Rogers R.C. Mo</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>494-40-2932</u>	17. INFORMANT <u>Andrew Rogers R.C. Mo</u> Address <u>3754</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of prostate</u>	
	DUE TO (c) <u>177X</u>	
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.)
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20c. TIME OF INJURY Hour <u>0</u> a.m. <u>0</u> p.m. <u>0</u>	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 <u>Harrisonville</u>	COUNTY <u>Mo</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>July 1956</u> to <u>9-16-58</u> and last saw her/him alive on <u>9-16-58</u> . Death occurred at <u>4 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Edward S. Jones, MD</u>	22b. ADDRESS <u>Harrisonville Mo</u>	22c. DATE SIGNED <u>9-17-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 18-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orion Cemetery Harrisonville Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Mo</u>
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24. FUNERAL DIRECTOR <u>Brunnenberg's Harrisonville</u>	25. DATE RECD. BY LOCAL REG. <u>Sept 18, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Dora Barnard</u>
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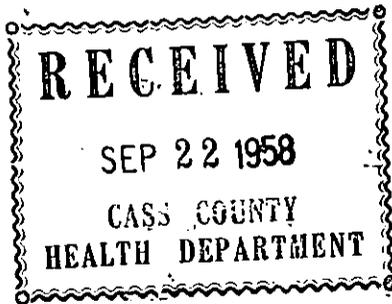
(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1570



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 Frank E. Runnenbeger, Student Embalmer No. 568 working under my personal supervision.

Student Frank E. Runnenbeger Signed James R. Phillips
Signature of Student Embalmer

Licensed Embalmer No. 4641

P. O. Address Harrisonville

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.