

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006297

STATE FILE NUMBER

FILED MAR 2 1959 Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 22

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Linn</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Brookfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McLarney Hospital</b>		Length of stay in lb <b>2 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>311 S. Livingston</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>JONES</b> Last <b>CLUBINE</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>22,</b> Year <b>1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1908</b>	9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>New Boston, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13a. FATHER'S NAME <b>Frank Richardson</b>		13b. MOTHER'S MAIDEN NAME <b>Clara Baker</b>	14. NAME OF HUSBAND OR WIFE <b>John Clubine</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>John Clubine, 311 S. Livingston, Brookfield</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary arrest</b>				INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Myocardial Infarction</b>		10 days	
		DUE TO (c) <b>Prob of coronary atherosclerosis</b>		ye	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>4281</b>				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 <b>3:30</b> Month, Day, Year a.m. <b>a</b> 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.) <b>Brookfield</b>	20f. CITY, TOWN, OR LOCATION <b>Linn</b>	COUNTY <b>Mo.</b>	STATE
21. I attended the deceased from <b>Feb 17 1959</b> to <b>Feb 17 59</b> and last saw him <sup>her</sup> alive on <b>Feb 22, 1959</b> Death occurred at <b>3:30 a</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>B D Howell</b> (Degree or title) <b>MO</b>			22b. ADDRESS <b>Brookfield Mo.</b>		22c. DATE SIGNED <b>2-23-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 24, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Brookfield, Mo.</b>	
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2-24-59</b>	26. REGISTRAR'S SIGNATURE <b>Katharine Johnson</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS  
OCT 23 1959

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 *Harsed B. Wright* .....

Licensed Embalmer No. 3718 .....

P. O. Address Brookfield, Mo. ....

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.