

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008401  
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 140

300

-57

1. PLACE OF DEATH a. COUNTY <b>Boone</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>WARREN</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Marthasville,</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>University of Mo. Med. Center. bluka</b>		Length of stay in lb.	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Charles Feldman</b>			4. DATE OF DEATH Month Day Year <b>March 25, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>9-25-17</b>	9. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	11. BIRTHPLACE (City and state or country) <b>Warren County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Oscar Feldman</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Rutherford</b>		14. NAME OF HUSBAND OR WIFE <b>Ivulette, Feldman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>498-33-3021</b>	17. INFORMANT Address <b>Patients Chart</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>CEREBRAL METASTASIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 WKS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>MALIGNANT MELANOMA, @ ARM</b>					10 Mo.
DUE TO (c)					
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 <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 <b>FEB 2, 1959</b> to <b>MAR. 25, 1959</b> and last saw her alive on <b>MAR 25, 1959</b> Death occurred at <b>10:15 PM CST</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Samuel P. W. Black, M.D.</b> (Degree or title)			22b. ADDRESS <b>University Med Center Columbia</b>		22c. DATE SIGNED <b>3/25/1959</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/28/1959</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or country) (State) <b>Marthasville, Mo</b>
24. FUNERAL DIRECTOR <b>Lynnan Sprinkle</b>		ADDRESS <b>Columbia Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mar. 26, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

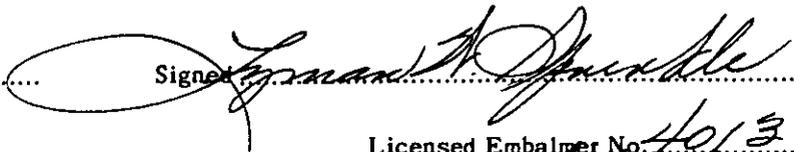
MEDICAL CERTIFICATION

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. 4013  
P. O. Address Columbia, 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.