

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015613  
STATE FILE NUMBER  
2 2170

FILED APR 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Vanderburgh</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Evansville</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>Barnes Hospital</b>		Length of stay in 1b	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 <b>Harold</b> Middle <b>G.</b> Last <b>Rininger</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>28,</b> Year <b>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>July 6, 1906</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>52</b> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Frank Rininger</b>		13b. MOTHER'S MAIDEN NAME <b>Katherine Yeager</b>	
14. NAME OF HUSBAND OR WIFE <b>Ruth Rininger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give branch of service) <b>Yes W. W. Mes 2</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Ruth Rininger, Evansville, Indiana</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>Barbiturate Intoxication</b> INTERVAL BETWEEN ONSET AND DEATH <b>E 970.2</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Self ingested (misadventure)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>prescribed at Barnes Hospital</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT, SUICIDE, HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DEATH OCCURRED <b>at Barnes Hospital</b>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>2:27 59</b>		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> Hosp</b>		20f. CITY, TOWN, OR LOCATION <b>St Louis Mo</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>245A</b> m on the date stated above; and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <b>Druck P Taylor</b>		22b. ADDRESS <b>300 Clark</b>	
22c. DATE SIGNED <b>3.2.59</b>		22d. DATE SIGNED <b>3.2.59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-28-59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockport, Indiana.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b>		25. DATE RECD. BY LOCAL REG. <b>MAR 2 '59</b>	
24. FUNERAL DIRECTOR ADDRESS <b>4700 Washington, Blvd.</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</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. 4108  
P. O. Address Harris

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.