

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028904

FILED VS AUG 24 1959

STATE FILE NUMBER

Registration District No. 241 Primary Registration District No. 555 Registrar's No. 107

DED

1. PLACE OF DEATH a. COUNTY <u>Naucell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Naucell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plain</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>West Plain</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lebo Rto</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Lebo Rto</u>	
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Frances</u> Last <u>Rutheman</u>			4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1864</u>	9. AGE (last birthday) <u>95</u>	IF UNDER 1 YEAR Month <u>4</u> Days <u>10</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>	11. BIRTHPLACE (City and state or country) <u>Orange Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>J. J. McDaniel</u>		13b. MOTHER'S MAIDEN NAME <u>Mary A. Black</u>		14. NAME OF HUSBAND OR WIFE <u>✓</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>✓</u>			16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Myrtle Bassett West Plain Mo</u>
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>Senility</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m. _____ Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Nov 3 - 59</u> and last saw her alive on <u>7-15-59</u> Death occurred at <u>12:00 minutes</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. J. St. M.D.</u> (Degree or title)			22b. ADDRESS <u>West Plain Mo</u>		22c. DATE SIGNED <u>8/18/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-19-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>		23d. LOCATION (City, town, or county) (State) <u>St. John Mo</u>	
24. FUNERAL DIRECTOR <u>Taberlons West Plain Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed D. S. Roberts

Licensed Embalmer No. 343

P. O. Address Westfield

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.