

RIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029800

FILED VS AUG 26 1959 209

3043

253

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MO b. COUNTY MARION	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN HANNIBAL		c. CITY OR TOWN HANNIBAL	
Length of stay in 1b 11 Yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LEVERING HOSP (DOA)		d. STREET ADDRESS (If outside, give location) 510 Lyon	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First AUBREY Middle BRYAN Last RUDISILL			4. DATE OF DEATH Month 8 Day 19 Year 1959			
---	--	--	---	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1897	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months 6 Days 2	IF UNDER 24 HR Hours 0 Min. 0
--------------------	-------------------------------	---	----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired STANDARD PRINTING CO	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MADISON, N.C.	12. CITIZEN OF WHAT COUNTRY U.S.
---	-----------------------------------	--	--

13a. FATHER'S NAME ROBERT RUDISILL	13b. MOTHER'S MAIDEN NAME AUGUSTA WITHERS	14. NAME OF HUSBAND OR WIFE CORA RUDISILL
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES	16. SOCIAL SECURITY NO. NO	17. INFORMANT CORA RUDISILL - Hannibal, MO	Address
--	--------------------------------------	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
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 2:45 a.m. 2 p.m.	Month, Day, Year 8/19/59
--	------------------------------------

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 HANNIBAL, MO	COUNTY MARION	STATE MO
---	--	---	-------------------------	--------------------

21. I attended the deceased from **8/19/59** to **8/19/59** and last saw her/him alive on **8/19/59**
Death occurred at **2:45 a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. W. Wattershead M.D. (Degree title)	22b. ADDRESS 508 Broadway, Hannibal, Mo	22c. DATE SIGNED 8/24/59
--	---	------------------------------------

23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	23b. DATE 8-22-1959	23c. NAME OF CEMETERY OR CREMATORY GRAND VIEW C.F.M.	23d. LOCATION (City, town, or county) (State) HANNIBAL, MO
--	-------------------------------	--	--

24. FUNERAL DIRECTOR LARK FUNERAL HOME	ADDRESS Hannibal, Mo	25. DATE RECD. BY LOCAL REG. 8-24-59	26. REGISTRAR'S SIGNATURE Dr. E. M. Lucke by W. Fisher
--	--------------------------------	--	--

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 *Ralph J. [Signature]*

Licensed Embalmer No. 4217

P. O. Address *[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.