

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS NOV 30 1959**

**59-041321**

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 140

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft Leonard Wood, Mo</u>		Length of stay in 1b		c. CITY OR TOWN <u>Ft Leonard Wood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>US Army Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>US Army Hospital</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Dale</u> Last <u>Rau</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>16</u> Year <u>59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-15-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours <u>17</u> Min <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <u>Ft Leonard Wood, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Edward James Rau</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Lea Hogan</u>		14. NAME OF HUSBAND OR WIFE -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. -----	17. INFORMANT Address <u>Edward Rau, Ft Leonard Wood, Missouri</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>Respiratory Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Atelectasis Lungs</u>							
DUE TO (c) <u>Eversionation of Diaphragm</u>							
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 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>15 Nov 59</u> to <u>16 Nov 59</u> and last saw <u>her</u> alive on <u>16 Nov 59</u> Death occurred at <u>1:10 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Hans H Baruch</u> (Degree or title) <u>Capt, MC</u> <u>HANS H BARUCH</u>				22b. ADDRESS <u>Ft Leonard Wood, Mo</u>		22c. DATE SIGNED <u>16 Nov 59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 20/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crocker Memorial</u>		23d. LOCATION (City, town, or county) <u>Crocker, Missouri</u>		(State)	
24. FUNERAL DIRECTOR <u>Hedges Funeral Home</u> Address <u>Crocker, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-20-59</u>		26. REGISTRAR'S SIGNATURE <u>Pauline Anderson</u>		

ENDED

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.