

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS DEC 17 1959

'59 045057

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.D.</u> b. COUNTY <u>Ramsey</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft Leonard Wood</u>		Length of stay in lb <u>9 hrs</u>		c. CITY OR TOWN <u>Morton</u>		Inside Limits Yes <input 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>111-9th NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Joseph</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>59</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-93</u>		
				9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____		
						IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (City and state or country) <u>Charles City Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Deceased</u>			13b. MOTHER'S MAIDEN NAME <u>Deceased</u>			14. NAME OF HUSBAND OR WIFE <u>Effie S. (Unk)</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes 18 yrs 6 mon</u>			16. SOCIAL SECURITY NO. <u>502-12-7764</u>		17. INFORMANT <u>Effie S. Kelly</u> Address <u>Waynesville, Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Retroperitoneal Hemorrhage</u>								
DUE TO (c) <u>Ruptured Abdominal Aorta</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 checked="" type="checkbox"/> NO <input 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>Nov 27, 1959</u> to <u>Nov 28, 1959</u> and last saw <sup>her</sup> him alive on <u>Nov 28, 1959</u> Death occurred at <u>2:30am</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>				22b. ADDRESS <u>US Army Hospital Ft Leonard Wood</u>			22c. DATE SIGNED <u>11-28-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12/2/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery.</u>		23d. LOCATION (City, town, or county) (State) <u>Leavenworth, Kansas.</u>		
24. FUNERAL DIRECTOR <u>Hedges Funeral Home</u> ADDRESS <u>Waynesville, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Eula Grace Anderson</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 18 1959 SA

FEB 19 1960

**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

*Clarence Moss*

Licensed Embalmer No. 4896

P. O. Address Waynesville, N.C.

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.