

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

**60-011381**

**FILED VS APR 12 1960**

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 196 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>24 hrs</b>	c. CITY OR TOWN <b>Independence</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>Independence Sanitarium</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>715 So Cottage</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Earnest</b> Middle <b>Delbert</b> Last <b>Ruth</b>			4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</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>12-16-1927</b>	9. AGE (last birthday) <b>32</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Gillam, Wis</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>John Ruth</b>		13b. MOTHER'S MAIDEN NAME <b>Myrtle Bohrn</b>		14. NAME OF HUSBAND OR WIFE <b>Ester Ruthh</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>493-26-0829</b>	17. INFORMANT <b>Mrs. Ester Ruth Independence, Mo</b>	Address <b>715 So Cottage</b>
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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 <b>8 wks</b>
IMMEDIATE CAUSE (a)	<b>Acute Myocardial Infarction</b>	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	<b>Cardiac Decomposition</b>	
DUE TO (b)	<b>Cardiac Decomposition</b>	
DUE TO (c)	<b>Pneumonia, Heart Dis.</b>	<b>yes</b>
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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 1955 to 4-2-60 and last saw <sup>her</sup>him alive on 4-2-60  
Death occurred at 3135 12m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>E. M. D.</i>	22b. ADDRESS <b>1210 Ash Independence Mo</b>	22c. DATE SIGNED <b>4-3-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-5-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Englewood</b>
24. FUNERAL DIRECTOR <b>Sickman &amp; Dunning Clinton Mo</b>	25. DATE RECD. BY LOCAL REG. <b>4-5-60</b>	26. REGISTRAR'S SIGNATURE <i>James H. King</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAR 23 1967

**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 Robert L. Dunn

Licensed Embalmer No. 4910

P. O. Address: Clinton

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.