

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 23 1960 53

=60-018632

Registration District No. _____ Primary Registration District No. 3009 Registrar's No. 197 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Girardeau</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>JACKSON</u>		Length of stay in lb <u>30 yrs</u>	c. CITY OR TOWN <u>JACKSON</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>314 Howard</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>314 Howard</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RUTH P.</u> Middle <u>KURRE</u> Last <u>KURRE</u>			4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>3/26/1907</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Charleston Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J. B. Penny</u>		13b. MOTHER'S MAIDEN NAME <u>Mollie Wills</u>		14. NAME OF HUSBAND OR WIFE <u>Milton Kurre</u>	
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. <u>None</u>	17. INFORMANT <u>Milton Kurre</u> Address <u>Jackson Mo</u> <u>314 Howard</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 <u>4 hrs</u>
IMMEDIATE CAUSE (a) <u>Right heart failure</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Severe right heart strain</u>	
	DUE TO (c) <u>Hammann-Rich Syndrome</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Para-esophageal hiatus hernia, large</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 Sept 11, 1948 to May 14, 1960 and last saw her alive on May 14, 1960
Death occurred at 12:36 p.m. on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE <u>J. H. Trolinger, MD</u>	(Degree or title)	22b. ADDRESS <u>J. H. TROLINGER, M. D.</u> <u>JACKSON, MISSOURI</u>	22c. DATE SIGNED <u>5/16/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/16/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Salem</u>	23d. LOCATION (City, town, or county) (State) <u>Daisy Mo.</u>
24. FUNERAL DIRECTOR <u>McCombs</u>	ADDRESS <u>Jackson Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-18-60</u>	26. REGISTRAR'S SIGNATURE <u>Lrene Kasten</u>

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 Bruce Dockins, Student Embalmer No. 598
working under my personal supervision.

Student Bruce Dockins
Signature of Student Embalmer

Signed B.A. Meyer

Licensed Embalmer No. 3051

P. O. Address Jackson, T.

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.