

ENDED

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 269

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Jasper</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jasper</u> | | | | | | | | | | | | |
| b. CITY (If corporate limits, give TOWNSHIP only) <u>Joplin Mo</u> | | Length of stay in 1b <u>4da</u> | | c. CITY OR TOWN <u>Saracape Mo</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | | |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hosp</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>Saracape Twp</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Goldie Ellen Rule</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1960</u> | | | | | | | | | | | | |
| 5. SEX <u>fe</u> | 6. COLOR OR RACE <u>wh</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>7-31-93</u> | 9. AGE (last birthday) <u>66</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | | | | | | | | | |
| 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> </u> | | 11. BIRTHPLACE (City and state or country) <u>Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | | | | | |
| 13a. FATHER'S NAME <u>unknown</u> | | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | | | 14. NAME OF HUSBAND OR WIFE <u>John F Rule</u> | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u> | | | 16. SOCIAL SECURITY NO. <u>446-18-9081</u> | | 17. INFORMANT Address <u>John F Rule Saracape 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>Medullary failure</u> | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral hemorrhage</u> | | | | | | | <u>5day</u> | | | | | | | | | |
| DUE TO (c) <u>Cerebral arteriosclerosis</u> | | | | | | | <u>5yr</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 <u> </u> a.m. <u> </u> p.m. <u> </u> | | | 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>5-22-60</u> to <u>5-25-60</u> and last saw her/him alive on <u>5-25-60</u> Death occurred at <u>5:00</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>James A Johnson DO</u> | | | | 22b. ADDRESS <u>521 N. 4th St. Joplin Mo</u> | | | | 22c. DATE SIGNED <u>5-26-60</u> | | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>5-27-1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunny Lane Cem</u> | | 23d. LOCATION (City, town, or county) (State) <u>Obba City, Mo</u> | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Jackson & Sons Saracape Mo</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>5-26-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Dovie Merriam</u> | | | | | | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0961 5 7001

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 Wm K. Jackson

Licensed Embalmer No. 3954

P. O. Address Jessie

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.