

FEDERAL BUREAU OF INVESTIGATION  
 FBI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025425

#2 351 161. Reg # A1339 317 Registration District No. 500 Registrar's No. 1797 STATE FILE NUMBER

FILED

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST. CLAIR</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		Length of stay in 1b <b>15 Days</b>	c. CITY OR TOWN <b>E. ST. LOUIS</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>VETERANS ADM HOSPITAL</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>12 JUDITH STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>B.</b> Last <b>RUTLEDGE SR.</b>			4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>60</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>6-29-73</b>	9. AGE (last birthday) <b>86</b>	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) <b>POLICE OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POLICE DEPARTMENT</b>	11. BIRTHPLACE (City and state or country) <b>LERoy, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>ROBERT RUTLEDGE</b>		13b. MOTHER'S MAIDEN NAME <b>MATHILDA JOHNSON</b>		14. NAME OF HUSBAND OR WIFE <b>MARGARET RUTLEDGE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPAN</b>		16. SOCIAL SECURITY NO. <b>333 01 7169</b>	17. INFORMANT Address <b>ILL. VIRGINIA ALLEN, 12 JUDITH ST. E. ST. LOUIS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>Undetermined</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>HEPATIC CIRRHOSIS</b>				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 <b>VA 5-25-60</b> to <b>6-9-60</b> Death occurred at <b>8 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>W. Oppler</b> (Degree or title) <b>W. OPPLER, M.D. DIRECTOR PROFESSIONAL SERVICE, VAH JEFF BRKS 25, MO.</b>			22b. ADDRESS		22c. DATE SIGNED <b>6-10-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6-10-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT CARMEL</b>	23d. LOCATION (City, town, or county) (State) <b>SIGNAL HILL, ILL.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>BRICHLER 2216 State E. St. Louis, Ill.</b>		25. DATE RECD. BY LOCAL REG. <b>6-10-60</b>	REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>			

**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 \_\_\_\_\_

ES-2 Licensed Embalmer No. \_\_\_\_\_

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

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.