

Dept. Health,  
 & Welfare  
 U. S. Public  
 Health Service

V. S. 300  
 Rev. 1-56

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All  
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED VS AUG 30 1960

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

=60-029860

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 337

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Pulaski</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cape Girardeau</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Mounds 9120</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>St. Francis Hospt. 10 Days</u>				Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>North Front Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Alfred</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male 2</u>	6. COLOR OR RACE <u>Negro</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>March 5, 1940</u>		9. AGE (In years last birthday) <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (City and state or country) <u>Mounds, Illinois 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Emmett James Lee</u>				14. MOTHER'S MAIDEN NAME <u>Clotee Mathis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>351-34-9428</u>		17. INFORMANT <u>Clotee Johnson, Ill.</u> P.O. Box 356, Mounds, Ill.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomyelitis.</u>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>+</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							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. _____		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>8/13/60</u> to <u>8/17/60</u> and last saw <u>him</u> alive on <u>8/17/60</u> . Death occurred at <u>7:30 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. H. Keim, M.D.</u> (Degree or title)				22b. ADDRESS <u>Cape Girardeau</u>		22c. DATE SIGNED <u>8/19/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Aug. 17, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spencer Heights</u>		23d. LOCATION (City, town, or county) (State) <u>Mounds, Illinois</u>	
24. FUNERAL DIRECTOR <u>Edward A. Puffin</u> 2501 Poplar St. Cairo, Illinois				25. DATE RECD. BY LOCAL REG. <u>8-23-60</u>		26. REGISTRAR'S SIGNATURE <u>Lune Kasten</u>	

AUG 31 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.....  
*Edward A. Ruffin*

Licensed Embalmer No. 5022  
2501 Poplar Street  
P. O. Address Cairo, Ill.

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.