

INDEXED

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 7727-60-022791

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b 2 wks		c. CITY OR TOWN Ferguson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hosp.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 9701 Green Valley Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Rudloff				4. DATE OF DEATH Month Day Year Aug. 4. 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/28/95	9. AGE (last birthday) 65	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) Dae Sharpner		10b. KIND OF BUSINESS OR INDUSTRY Shoe Mfrg.		11. BIRTHPLACE (City and state or country) St. Genevieve, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Wm. Rudloff			13b. MOTHER'S MAIDEN NAME Lina Cambron		14. NAME OF HUSBAND OR WIFE Corinne Ruddloff		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI			16. SOCIAL SECURITY NO. 494-10-0168		17. INFORMANT Address Corinne Rudloff 9701 Green Valley Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Monocytic Leukemia							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) 204.2
DUE TO (c)							
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 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 April 20, 1960 to Aug. 4th 1960 and last saw him alive on 8/4/60 Death occurred at Christian Hosp.							
22a. SIGNATURE P. H. Bernatorff MD				22b. ADDRESS 10093 W. Florissant		22c. DATE SIGNED 8/5/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/8/60		23c. NAME OF CEMETERY OR CREMATORY Calvary Cem.		23d. LOCATION (City, town, or county) St. Louis, Mo.	
24. FUNERAL DIRECTOR Ortmann F Home 9222 Lackland				25. DATE RECD. BY LOCAL REG. AUG 5 1960		26. REGISTRAR'S SIGNATURE Kearl Smith	

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al C Ostmann

Licensed Embalmer No. 3478

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.