

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS AUG 24 1960

318

1003

8135-60-032797
 STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4365 St. Louis			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Ruffin				4. DATE OF DEATH Month Day Year 8 6 60			
5. SEX Fem.	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-6-60	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min. 3 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Saint Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Eugene Ruffin			13b. MOTHER'S MAIDEN NAME Thelma Jackson			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs. Mary A. Pitt, R.R. 1.</i> 2601 N. Whittier		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complete Atelectasis of Lungs							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Severe Prematurity							
DUE TO (c) 76 2.5							
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"/> N- <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 8-6-60 to 8-6-60 and last saw her him alive on 8-6-60 Death occurred at 9:00 a. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Loard Smith</i> (Print or title) Loard Smith, M. D.			22b. ADDRESS 2601 N. Whittier			22c. DATE SIGNED 8-9-60	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE AUG 31 1960	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board			23d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
24. FUNERAL DIRECTOR Rowland Mortuary Svc.		ADDRESS 4104-06 Manchester		25. DATE RECD. BY LOCAL REG. AUG 18 1960		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M. D.</i>	

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 _____

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.