

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 12 1960

75 -60-040912

INDEXED

Registration District No. 002 Primary Registration District No. 4097 Registrar's No. 74 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Andrew</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Amazonia</b>		c. CITY OR TOWN <b>Amazonia</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>At home</b>		Length of stay in 1b <b>23 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>None</b>
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>RUDOLPH</b> Last <b>RUDOLPH</b>			4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/1870</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Frutigen Switzerland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>Samuel Egger</b>		13b. MOTHER'S MAIDEN NAME <b>Rosina Klopferstein</b>		14. NAME OF HUSBAND OR WIFE <b>Max R. Rudolph (Deceased)</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Lydia Bowman</b> Address <b>Amazonia, Mo.</b>		

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) <b>Bronchial Pneumonia</b>		<b>2 weeks</b>
DUE TO (b) <b>Cardio-vascular-renal disease</b>		<b>5 years</b>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Fractured hip. Totally bedfast.</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 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 <b>4-3-48</b> to <b>11-26-60</b> and last saw <b>her</b> alive on <b>11-25-60</b>		Death occurred at <b>12:30P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <b>Pallie R. Kelly MD</b>		22b. ADDRESS <b>Savannah, Missouri</b>	22c. DATE SIGNED <b>11-28-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/28/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Amazonia Missouri</b>
24. FUNERAL DIRECTOR <b>Atamer Funeral Home</b> ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-5-60</b>	26. REGISTRAR'S SIGNATURE <b>Kellian Spikes</b>

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 Charles E Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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.