

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 13 1960

53

Registration District No. \_\_\_\_\_ Primary Registration District No. 3010

Registrar's No. 483

=60-041274  
STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>CAPE GIRARDEAU</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>CAPE GIRARDEAU</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CAPE GIRARDEAU</b>		Length of stay in 1b <b>1 DAY</b>		c. CITY OR TOWN <b>CAPE GIRARDEAU</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>HAVEN OF REST NURSING HOME</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>602 GOOD HOPE ST.</b>		
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUSSELL HOLMAN JUDEN JR.</b>				4. DATE OF DEATH Month Day Year <b>Nov. 30, 1960</b>				
5. SEX <b>MALE</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>SEPT. 17, 1878</b>		
9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>2 13</b>		IF UNDER 24 HR				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>FARMER (RET.)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and state or country) <b>CAPE GIRARDEAU, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>RUSSELL HOLMAN JUDEN SR.</b>			13b. MOTHER'S MAIDEN NAME <b>ANNIE R. MILLER</b>			14. NAME OF HUSBAND OR WIFE <b>RHODA MAY JUDEN</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 Address <b>CLARA ANN JUDEN - CHAFFEE, MO.</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>Acute Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>							<b>30 yrs</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>Pulmonary Fibrosis</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>Jan 1957</b> to <b>30 Nov 60</b> and last saw him alive on <b>30 Nov 60</b> Death occurred at <b>4:35 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>R E Trubble MD</b> (Degree or title)				22b. ADDRESS <b>Chaffee Mo</b>		22c. DATE SIGNED <b>2 Dec 60</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 2, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>CAPE GIRARDEAU, MO.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>BISPLINGHOFF FUNERAL HOME - CHAFFEE, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>12-7-1960</b>		26. REGISTRAR'S SIGNATURE <b>Dennis Kasten</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 Jack T. Burnett

Licensed Embalmer No. 4473

P. O. Address Chaffee, 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.