

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-046315

FILED VS DEC 3 0 1960

6178

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clay					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City		Length of stay in 1b 5 Hours		c. CITY OR TOWN Gladstone		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6801 North Prospect		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First N I N A Middle E. Last R U E D E				4. DATE OF DEATH Month December Day 6, Year 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1891	9. AGE (last birthday) 68	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) Bookkeeper			10b. KIND OF BUSINESS OR INDUSTRY Bowers Garage Co.		11. BIRTHPLACE (City and state or country) Woodville, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME James Henry Ruede			13b. MOTHER'S MAIDEN NAME Sarah Belle Hand			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) No			16. SOCIAL SECURITY NO. 487-07-8352		17. INFORMANT Miss Carrie I. Ruede, Kansas City 19, Mo. Address 6801 N. Prospect				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aneurysm							INTERVAL BETWEEN ONSET AND DEATH 1 month.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic dilatation of aorta.						76 months		
	DUE TO (c) Myoperctenion						normal years		
	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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 May 5, 1960 to December 6, 1960 and last saw her/him alive on December 6, 1960 Death occurred at 10:40 PM m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) B Comer Bates, M.D.				22b. ADDRESS 2730 North Wall Antioch Kansas City, Mo.			22c. DATE SIGNED 12/8/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 9, 1960	23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri.				
24. FUNERAL DIRECTOR Freeman Mortuary, Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 12-8-60		26. REGISTRAR'S SIGNATURE H. L. Dwyer			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Cooper Bates

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address Kansas C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.