

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017136

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Dr. Schwartz
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 531

STATE FILE NUMBER

AMENDED

FILED MAY 29 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 17 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3014 W. OLIVE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3014 W. OLIVE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last KATHRYN RUZICKA			4. DATE OF DEATH Month Day Year MAY 24 1951
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 11/28/36
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 24 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) BOLIVAR, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME ALOIS C. RUZICKA		13b. MOTHER'S MAIDEN NAME EMMA FRANCKA	14. NAME OF HUSBAND OR WIFE X
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. NO	17. INFORMANT Address ALOIS C. RUZICKA, SPRINGFIELD, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pneumonia</u> DUE TO (b) <u>Cerebral Palsy, severe</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day since birth</u>
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 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 Month, Day, Year a.m. p.m.		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 <u>5-23-61</u> to <u>5-24-61</u> and last saw her <u>her</u> alive on <u>5-23-61</u> Death occurred at <u>5:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E.J. Schwartz M.D.</u> (Degree or title)		22b. ADDRESS <u>609 Cherry, Springfield Mo</u>	22c. DATE SIGNED <u>5-26-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE <u>5/27/61</u>	23c. NAME OF CEMETERY OR CREMATORY ST. WENCESLOUS	23d. LOCATION (City, town, or county) (State) KARLIN, MISSOURI
24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME SPRINGFIELD, MO.		25. DATE RECD. BY LOCAL REG. <u>5-26-61</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Maeton</u>

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed W. J. McCann

Licensed Embalmer No. 2127

P. O. Address W. J. McCann

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.