

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-019633

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 13-1962 Primary Registration District No. 3044 Registrar's No. 29

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>MILLER</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>MILLER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELDON</u>		Length of stay in lb <u>2 yrs</u>	c. CITY OR TOWN <u>ELDON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>302-LOCUST</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>302-LOCUST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rush Rutherford-Stagner</u>		4. DATE OF DEATH Month Day Year <u>MAY-23-1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Sept-1881</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen-Farming</u>	11. BIRTHPLACE (City and state or country) <u>Livingston-Co-Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>JOHN-STAGNER</u>	
13b. MOTHER'S MAIDEN NAME <u>SARRAH</u>		14. NAME OF HUSBAND OR WIFE <u>ETTA-STAGNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Etta-Stagner</u>		Address <u>ELDON-MO</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> DUE TO (b) <u>Arteriosclerosis</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>30 min.</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 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.) <u>NONE</u>	
20c. TIME OF INJURY Hour a.m. p.m. <u>NONE</u>	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.) <u>NONE</u>	20f. CITY, TOWN, OR LOCATION <u>NONE</u>
21. I attended the deceased from <u>MARCH 1962</u> to <u>MAY 23 1962</u> and <u>May 23 1962</u> saw him alive on <u>May 23 1962</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>E. O. Shelton M.D.</u> (Degree or title)	
22b. ADDRESS <u>ELDON MO</u>		22c. DATE SIGNED <u>24-MAY-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>25 MAY-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ELDON</u>	23d. LOCATION (City, town, or county) (State) <u>ELDON MO</u>
24. FUNERAL DIRECTOR <u>Keith McFays</u> ADDRESS <u>ELDON-MO</u>		25. DATE RECD. BY LOCAL REG. <u>May 25, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Aldveretta Waltz</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 Keith M Kaye  
Licensed Embalmer No. 3998  
P. O. Address Eldon Mo

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.