

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-030669

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1328

STATE FILE NUMBER

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p>FILED SEP 10 1962</p>		<p>1. PLACE OF DEATH</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p>	
<p>a. COUNTY Greene</p>		<p>b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Springfield</p>		<p>a. STATE Missouri b. COUNTY Greene</p>	
<p>c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Burge Hospital</p>		<p>Length of stay in 1b</p>		<p>c. CITY OR TOWN Springfield</p>	
<p>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>d. STREET ADDRESS 2130 N. Travis</p>		<p>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;">First Middle Last ARCH MURRY RUTLEDGE</p>			<p>4. DATE OF DEATH</p> <p style="text-align: center;">Month Day Year September 2, 1962</p>		
<p>5. SEX Male</p>	<p>6. COLOR OR RACE White</p>	<p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 9/15/1903</p>	<p>9. AGE (last birthday) 58</p>	<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY Retired</p>		<p>11. BIRTHPLACE (City and state or country) Missouri</p>	
<p>12. CITIZEN OF WHAT COUNTRY USA</p>		<p>13a. FATHER'S NAME William A. Rutledge</p>		<p>13b. MOTHER'S MAIDEN NAME Callie Barrow</p>	
<p>14. NAME OF HUSBAND OR WIFE None</p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. No</p>	
<p>17. INFORMANT Mary Painter (Sister) Springfield, Mo.</p>		<p>Address Rt. #1</p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p>	
<p>IMMEDIATE CAUSE (a) Presumed to be natural causes</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>		<p>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</p>	
<p>DUE TO (b) UNATTENDED BY A PHYSICIAN</p>		<p>DUE TO (c)</p>		<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>	
<p>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</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Deceased had been in ill health for a long time.</p>		<p>20c. TIME OF INJURY Hour a.m. p.m.</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY STATE</p>	
<p>21. I attended the deceased from _____ to 9/2/62 and last saw ^{her} _{him} alive on _____</p>		<p>Death occurred at 9:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>		<p>22a. SIGNATURE <i>[Signature]</i> (Degree or title) Greene County Health Officer, Springfield, Mo</p>	
<p>22b. ADDRESS</p>		<p>22c. DATE SIGNED 9-6-62</p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>	
<p>23b. DATE 9-4-62</p>		<p>23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery</p>		<p>23d. LOCATION (City, town, or county) (State) Springfield, Missouri</p>	
<p>24. FUNERAL DIRECTOR KLINGNER MORTUARY, INC. Springfield, Mo.</p>		<p>25. DATE RECD. BY LOCAL REG. 9-7-62</p>		<p>26. REGISTRAR'S SIGNATURE <i>[Signature]</i></p>	

USE BLACK INK OR TYPEWRITER RIBBON

jhc

(Licensed Embalmer's Statement on Reverse Side)

OCT 17 1962

Permit
Sept 4, 1962

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 Oyle Stone Jr

Licensed Embalmer No. 4176

P. O. Address Springfield

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.