

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037348

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 196

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Scott</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston, Missouri</u> Length of stay in lb <u>Few Hours</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u> c. CITY OR TOWN <u>East St. Louis, Ill</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1720 Converse Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Jessie</u> Last <u>Rucker</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>25</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Unknown</u>
<b>9. AGE</b> (last birthday) <u>About 38</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR. Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unemployed</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>East St. Louis, Ill.</u>
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		<b>13a. FATHER'S NAME</b> <u>James Rucker</u>	
<b>13b. MOTHER'S MAIDEN NAME</b> <u>Willie Ruth Lillard</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	<b>17. INFORMANT</b> <u>James Rucker, 1720 Converse Ave. Illinois</u> Address <u>East St. Louis</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion and laceration of brain</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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). <u>Crushing injuries to chest, multiple leg fracture, fracture of mandible</u>		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	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>auto struck tree</u>	
<b>20c. TIME OF INJURY</b> <u>4:20 p.m.</u> Month, Day, Year <u>8 25 62</u>		<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>		<b>20f. CITY, TOWN, OR LOCATION</b> <u>New Madrid</u>	COUNTY <u>MO</u> STATE <u>  </u>
<b>21. I attended the deceased from</b> <u>8/25/62</u> , to <u>8/25/62</u> and last saw <sup>her</sup> him alive on <u>8/25/62</u> Death occurred at <u>6:10 PM</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <u>Wm. C. Cutchlaw M.D.</u>		<b>22b. ADDRESS</b> <u>Sikeston, MO</u>	<b>22c. DATE SIGNED</b> <u>Aug 26, 1962</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>8/31/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset Gardens of Memory</u>	<b>23d. LOCATION</b> (City, town, or county) <u>Stokey Township, Illinois</u> (State) <u>  </u>
<b>24. FUNERAL DIRECTOR</b> <u>Marion's Office</u> ADDRESS <u>2114 Missouri Avenue E. St. Louis, Illinois</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept 11-1962</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Jeanette Waldman</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

VS 300 Rev. 4/59  
 11007  
 29120  
 3  
 4 2  
 5 0  
 6  
 7 1  
 8 2  
 9 X  
 10  
 11092  
 121-0  
 132-0  
 USE BLACK INK OR TYPEWRITER RIBBON

*Permit renewed Aug 25 - 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 *Marion D. Offner*

Licensed Embalmer No. 5177

P. O. Address St. Louis, 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.