

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-027098

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 4 Primary Registration District No. 5026 Registrar's No. 74

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 14 1963

1. PLACE OF DEATH a. COUNTY <u>Atchison</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>near Fairfax Mo</u> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>enroute to Fairfax Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Atchison</u> c. CITY OR TOWN <u>Rock-Port Mo</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) <u>Ruthie Mae Whitel</u>			4. DATE OF DEATH <u>Aug 5, 1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7-1894</u>	9. AGE (last birthday) <u>69</u>	10. UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>A. J. Maxwell</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth F. Stealey</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Whitel (deceased)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>[redacted]</u>	17. INFORMANT <u>Mildred Lininger Rock-Port Mo</u>

18. CAUSE OF DEATH (Enter only one cause per line)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u>	DUE TO (b) <u>Arterio sclerotic heart disease</u>	<u>one hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	<u>5 years</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	
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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 a.m. p.m.	Month, Day, Year		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>July 1958</u> to <u>Aug 5-63</u> and last saw ^{her} him alive on <u>8-8-63</u> Death occurred at <u>9:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>Wallace Carpenter MD</u>		22b. ADDRESS <u>Rock-Port Mo</u>	22c. DATE SIGNED <u>8-8-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Aug 8-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill cemetery</u>	23d. LOCATION (City, town, or county) <u>Marionville Mo</u>
24. FUNERAL DIRECTOR <u>Bertram Funeral Home - Rock-Port Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 10, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Marvin N. Schaefer</u>

(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 *C. E. Bertram*

Licensed Embalmer No. *1764*

P. O. Address *Rock Road 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.