MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. NO. 2.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Carroll

Township Dewitt

or

Village

or

City (NO. 5794 St.; Ward)

Registration District No. 136 File No. 6 4462

Primary Registration District No. ~~4076~~ Registered No. 6

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William. S. Ruckel.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: January (Month) 26th (Day) 1827 (Year)

AGE: 85 yrs. mos. 24 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 1-00

BIRTHPLACE (City or town, State or foreign country): Ore co Columbia Pen

PARENTS

NAME OF FATHER: Jacob Ruckle

BIRTHPLACE OF FATHER (City or town, State or foreign country): Columbia Co Pen

MAIDEN NAME OF MOTHER: Martha C. Hazlett Northup

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Bluff Co. Pen

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. S. Ruckel

(ADDRESS) Norborne MO

Filed Feb 19, 1912 John P Logan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: February 19th (Month) (Day) 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from January 9th, 1912, to Feb 19th, 1912, that I last saw him alive on Feb 19th, 1912, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pericarditis acute

107A

90B (Duration) yrs. mos. 41 ds.

Contributory (SECONDARY) Bronch Pneumel

(Duration) yrs. mos. ds.

(Signed) John P Logan M. D.

Feb. 19 1912 (Address) Dewitt MO

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Dewitt, Cuty

DATE OF BURIAL: Febry 21 1912

UNDERTAKER: McClellan, Bros

ADDRESS: Dewitt Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED- (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) *1*____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MARGIN RESERVED FOR BINDING