

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

Do not use this space.

23102

**1. PLACE OF DEATH**

County..... Registration District No. 791  
Township..... Primary Registration District No. 1003  
City St. Louis (No. City Hospital)

File No. ....  
Registered No. 6795  
St. .... Ward)

**2. FULL NAME**

4780 William R. Ruman  
(a) Residence. No. 2122 E. Chamer St., 9 Ward. (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Ruman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
60 4 3

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) day  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis  
(STATE OR COUNTRY)

10. NAME OF FATHER Wm Ruman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany  
(STATE OR COUNTRY)

14. INFORMANT Wm Ruman  
(Address) City Hospital

15. FILED 11 27 1927 Max C. Starckoff  
19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 20 1927

17. I HEREBY CERTIFY That I attended deceased from July 14 1927 to July 20 1927  
that I last saw him alive on July 25 1927, and that death occurred, on the date stated above, at City Hospital

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Myocarditis  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) 90 B  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. J. ... M. D.  
7/25/27 (Address) City Hospital

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Birklehay DATE OF BURIAL July 27 1927

20. UNDERTAKER Thos H. Biederwieser ADDRESS 1436 St. Louis Ave

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.

RECORD

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