

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

Do not use this space.

6491

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis Mo.* (No. *No.*)

Sanitarium

File No.

Registered No. **1303**

St. Ward)

2. FULL NAME

Ruth Ross

(a) Residence. No. *4328 1/2* *Laclade Ave.* *13* Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *61* yrs. *4* mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

June 22, 1834

7. AGE

YEARS *95*

MONTHS *7*

DAY *13*

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer).....

"

(c) Name of employer.....

"

9. BIRTHPLACE (CITY OR TOWN)

Monroe County

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Monroe County

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

"

(STATE OR COUNTRY)

"

14.

INFORMANT

(Address)

William T. Gutter 200

5400 Arsenal St.

15.

FILED

19 *1935*

Wm C. Standley

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Febr 5, 1930

17.

HEREBY CERTIFY, That I attended deceased from *July 1, 1929*, to *Febr 5, 1930*, that I last saw her alive on *Febr 5, 1930*, and that death occurred, on the date stated above, at *8:55 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930
97

(duration) *1* yrs. *2* mos. *24* ds. *+*

CONTRIBUTORY (SECONDARY)

Arteriosclerosis

(duration) *1* yrs. *2* mos. *24* ds. *+*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Unknown

DID AN OPERATION PRECEDE DEATH? *No.* DATE OF

WAS THERE AN AUTOPSY? *No.*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *William T. Gutter*, M. D.

2/6, 1930 (Address) *5400 Arsenal St.*

*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

DATE OF BURIAL

Ballfontain Cem

1930

20. UNDERTAKER

ADDRESS

Wm C. Hollins 2284 Grand

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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