NOV 14 1939

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

35088
Do not use this space.

**1. PLACE OF DEATH**

(a) County Jackson — Registration District No. 399

(b) Township Kaw — Primary Registration District No. — Registered No. 4063

(c) City K. C. Mo — (d) Street No. 809 West 23rd Street St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Rachel Delores Ruiz

(a) Residence, No. 809 West 23rd St. K. C. Mo. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 11, 1938

7. AGE: YEARS 11 — MONTHS 9 — DAYS 11 — If LESS than 1 day, ....hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri 0

FATHER
13. NAME: Modesta Ruiz 3
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mexico 3

MOTHER
15. MAIDEN NAME: Adrian Cabrera
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mexico

17. INFORMANT (ADDRESS): Mr. Modesta Ruiz, 809 West 23rd St.

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Marys DATE Oct. 24 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Weilert Funeral Home, 2332 Monitor Place K.C.Mo.

20. FILED 10/23, 1939 M. M. Crowe, Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 10-22-39

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... I last saw her alive on ....., 19.... Death is said to have occurred on the date stated above, at 6:30 P.M. The principal cause of death and related causes of importance were as follows:

Date of onset

Fracture of the skull
Subdural cerebral hemorrhage

Other contributory causes of importance: 1948

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Do not know Date of injury ....., 19....
Where did injury occur? " (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Do not know
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [signature], M. D.
(Address) K. C. Mo

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(Licensed Embalmer's Statement on Reverse Side)

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.

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## 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 .....,

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**