

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

132613.1. **RECORDED NOV 14 1939**

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

36063
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 750
 (c) City Springfield (d) Street No. St. John's Hospital 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 Jasper Wesley Ruggles
 (a) Residence, No. 1326 Belmont 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 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 Effie May Ruggles

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 2 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Engineer

9. Industry or business in which work was done, as saw mill, bank, etc. Frisco Ry. Co.

10. Date deceased last worked at this occupation (month and year) retired 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buffalo, Missouri

13. NAME George Ruggles

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Rachel Woodli

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Mrs. Effie May Ruggles
 (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL Monett Mo.
 PLACE I.O.O.F. Cemetery DATE Oct. 10, 1939

19. FUNERAL DIRECTOR Callaway's
 (ADDRESS) Monett

20. FILED Oct 8 1939 Chas A. George
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8, 1939 1939

22. I HEREBY CERTIFY, That I attended deceased from 9/30, 1939 to 10/8, 1939.
 I last saw him alive on 10/9, 1939 Death is said to have occurred on the date stated above, at 2:37 a.m.
 The principal cause of death and related causes of importance were as follows:
Sublethal obstruction Date of onset 4/6

Other contributory causes of importance:
Malignancy

Name of operation None Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ 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 _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) Chas A. George, M. D.
 (Address) Springfield Mo

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.

I 212004

STATEMENT BY LICENSED EMBALMER

I, J. W. Buchanan

Licensed Embalmer No. 3149

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed J. W. Buchanan

Licensed Embalmer No. 3149

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 360675
Registrar's No. 750

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... years, months or days)

3. (a) PRINT FULL NAME

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....
11. Industry or business.....
MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....
17. (a) (Burial, cremation, or removal) (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....
19. (a) 6-15-40 (b) W. E. Handley, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. 8 day 29 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19..... and that death occurred on the date and hour stated above.
Immediate cause of death.....

Intestinal obstruction
Due to malignancy
Due to no further information, as no autopsy was held
Other conditions..... (Include pregnancy within 3 months of death)

Major findings: Of operations..... 578
Of autopsy.....
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

