

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.

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

36622  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Macon Registration District No. 530  
 (b) Township Eastley Primary Registration District No. 5708  
 (c) City La-Crosse (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (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.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME Ruby Fern Wagner  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 17 1939  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
0 0 0  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 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) Mo  
 FATHER 13. NAME Wagner  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo  
 MOTHER 15. MAIDEN NAME Ruby Eastley  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo  
 17. INFORMANT (ADDRESS) H. C. Mayert  
La Crosse  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Indian Hill DATE June 17, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. M. Collins  
South 4th St. La Crosse  
 20. FILED Nov 10 1939 Mar Lloyd Baker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 17 1939  
 22. I HEREBY CERTIFY that I attended deceased from June 17 1939 to June 17 1939  
 I last saw her alive on at 10 a.m. 19\_\_\_\_ Death is said to have occurred on the date stated above, at 10 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Stillborn - a high knot was found in the cord causing strangulation  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Ruby M. Tillet M. D. 0  
4723 (Address) La Crosse Mo 3

RECEIVED

District Health Officer No: 10

District File Number 11-39-2026

Date Filed NOV 17 1939

**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.**