

Registration District No. **431**

Primary Registration District No. **5588**

Registrar's No. **64**

1. PLACE OF DEATH

(a) County Johnson
(b) City or town Warrensburg
(c) Name of hospital or institution: 2

(If not in hospital or institution, write street number or location)

(d) Length of stay: in hospital or institution 1 year & 4 months

In this community 2
years, months or days

3. (a) PRINT FULL NAME J. M. Ruff 100

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Oct 4 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>57</u>	<u>7</u>	<u>16</u>	hr. min.

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

10. Usual occupation Unknown

11. Industry or business Farmer

12. Name James Ruff

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

14. Maiden name Fallie Driggers

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

16. (a) Informant County Home

(b) Address Warrensburg

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Kingsville

18. (a) Signature of funeral director J. W. Goodman

(b) Address Holden Mo. 391

19. (a) May 20-40 (b) Eva Gentry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Johnson

(c) City or town Warrensburg
(If outside city or town limits, write "RURAL")

(d) Street No. County Home
(If rural, give location)

(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20
(year 1940 hour 12 noon M.)

21. I hereby certify that I attended the deceased from May 10
1940 to May 20 1940

that I last saw him alive on May 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Tubercular meningitis

Due to 74

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations —

Of autopsy —

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 J. S. Bradley (M. D. or other) —

Address Warrensburg Mo Date signed May 20

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

DATE FILED 6-5-110
FEDERAL FILE NUMBER
HEALTH OFFICER NO. 8
RECORDED

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 Samuel B. Popp.

Licensed Embalmer No. 4844

P.O. Address Halder, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 188H

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 431

Primary Registration District No. 53-88

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Warrensburg, T.P.
(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 _____ (Specify whether _____)
years, months or days

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.

3. (a) PRINT FULL NAME Joe M. Raff

(b) If veteran, name war _____

(c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 20
year 1940 hour _____ minute _____ M.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

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

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

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>7</u>	<u>16</u>	hrs. min.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

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

10. Usual occupation _____

Major findings: _____

Of operations _____

Of autopsy _____

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)

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 _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

22. Signature T. S. Bradley (M. D. or other) _____

Address Warrensburg Date signed _____

19. (a) July 30-40 (b) Bertie Hentley
(Date received local registrar) (Registrar's signature)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

S-18811