

MAR 19 1941 771
Registration District No. _____

Primary Registration District No. **6017**

Registrar's No. _____

74
00

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

1. PLACE OF DEATH: **St. Francois**

(a) County **St. Francois**

(b) City or town _____
(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 **48** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Francois**

(c) City or town **Rural** **94**
(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.? **0** years.

3. (a) PRINT FULL NAME **Hellen Dorothy Honoretta Ruh-**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **6** year **1941** hour **12:5** minute **5 AM**

4. Sex **Female** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Henry Ruh-**

6. (c) Age of husband **82** years **30** (Day) **1857** (Year)

7. Birth date of deceased **Aug** (Month) **30** (Day) **1857** (Year)

21. I hereby certify that I attended the deceased from **2-1**, 19**41** to **2-6**, 19**41**; that I last saw her alive on **2-5**, 19**41**; and that death occurred on the date and hour stated above.

8. AGE: Years **83** Months **5** Days **6** If less than one day _____ hr. _____ min.

Immediate cause of death **Bronchitis**

Due to **Influenza**

Due to _____

Other conditions **none**
(Include pregnancy within 3 months of death)

9. Birthplace **Buffalo N.Y.** (City, town, or county) **1** (State or foreign country)

10. Usual occupation _____

11. Industry or business **Housekeeper**

MOTHER FATHER

12. Name **John H. Grasshoff**

13. Birthplace **Deal Haven** (City, town, or county) **Germany** (State or foreign country)

14. Maiden name **Carolina Kudersting**

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

PHYSICIAN

Major findings: **no**

Of operations _____

Of autopsy **no**

Underline the cause to which death should be charged statistically.

16. (a) Informant **Walter Batright**

(b) Address **Frontier Rd**

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? _____

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Feb 8 1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Dequon 200F**

18. (a) Signature of funeral director **Sparks**

(b) Address **East Sparta**

696 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

19. (a) **Ore. 6 1941** (Date received local registrar) (b) **L. W. Gale** (Registrar's signature)

23. Signature **James W. Hoffmann** (M. D. or other) **D**
Address **Resident 7th** Date signed **2-6-41**

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

Ewert Sparks

Licensed Embalmer No.

2639

P. O. Address

Elvina M.

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, fact should be so stated above.