

No. 2  
13-40  
17-39  
X23159

FILED SEP 12 1941  
Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 261

1. PLACE OF DEATH:  
(a) County Pettis  
(b) City or town Bedalia  
(c) Name of hospital or institution: Cashwell  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME SARAH RUSKIN  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife Reubin 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years about 100 Months — Days — If less than one day hr. — min. —

9. Birthplace Russia 6  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace Russia 6  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Russia 6  
(City, town, or county) (State or foreign country)

16. (a) Informant Simon Kauter

(b) Address 201 W main

17. (a) Removal (b) Date thereof 8/15/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation K.C. Mo

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Pettis 80  
(c) City or town Bedalia, Mo. 6  
(If outside city or town limits, write "RURAL") 4  
(d) Street No. 406 Dalwhine 0  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug, day 14  
year 1941 hour 9 minute 45 A. M.  
21. I hereby certify that I attended the deceased from July 10  
1941, to Aug 14, 1941;  
that I last saw her alive on Aug 14, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis 6 mo  
Duration  
Due to none  
Due to none  
Other conditions Arteriosclerosis  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: none  
Of operations \_\_\_\_\_  
Of autopsy none  
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) no  
(b) Date of occurrence none  
(c) Where did injury occur? none  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? none (Specify type of place) (e) Means of injury none  
23. Signature Chas. A. Kewice (M. D. number) 1  
Address Bedalia Mo. Date signed 8/14/41

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

MOTHER FATHER

128

202

Date Filed 9-10-71  
District File Number  
District Health Officer No. 8,

RECEIVED

**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, fact should be so stated above.

14 4/18

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29064

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Sedalia  
(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)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Ruskin

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

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

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

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

8. AGE: Years about 100 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day \_\_\_\_\_ year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_; that I personally saw him/her alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Carcinoma of Esophagus  
Primary in esophagus  
(no other involvement)  
Due to \_\_\_\_\_

Other conditions Senile dementia  
(Include pregnancy within 3 months of death) late return

Major findings: \_\_\_\_\_  
Of operations none  
Of autopsy none made

Duration

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) none

(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 Chas. ... (M. D. or other)

Address Redevelopment Date signed out 11/19

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

SUPPLEMENTARY

