

FILED JUN 15 1942

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

18101
Do not use this space.

AGE OF DEATH

(a) County Howard, Registration District No. 378
(b) Township _____ Primary Registration District No. 4222 Registered No. 30
(c) City Fayette, (d) Street No. _____ 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 Dr Robert Hemrick Ruff
(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 Male 0
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed 2

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Nancy Ruff, (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 27th 1887

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
54 10 8

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. President
9. Industry or business in which work was done, as saw mill, bank, etc. Central College
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) Mississippi 1

FATHER
13. NAME Dr Robert Hamrick Ruff,

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mississippi 1

MOTHER
15. MAIDEN NAME Mary Hamrick,

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina 1

17. INFORMANT (ADDRESS) Henry Riser,
Memphis Tenn,

18. BURIAL, CREMATION, OR REMOVAL PLACE Nashville DATE 5-7th 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wuy T. Halley,
Fayette Mo.

20. FILED May 6 1942 Thomas B. Denny
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-5 1942

22. I HEREBY CERTIFY, That I attended deceased from Jan 5 1942, to 5-5 1942

I last saw him alive on 5-5 1942 Death is said to have occurred on the date stated above, at 6:00 m.

The principal cause of death and related causes of importance were as follows:

Cirrhosis of Liver
1248

Date of onset
1940

Other contributory causes of importance:

Chor. Cardio-Vasc. Renal disease 1939

Name of operation none Date of _____

What test confirmed diagnosis? Lab 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) W. D. Bloom

(Address) Fayette Mo

(M. D.)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 6-13-48

AUG 31 1948

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 Guy T. Hallen

Licensed Embalmer No. 2966

P. O. Address Fayette 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. 18101
Registrar's No. 30

Registration District No. 378 Primary Registration District No. 422

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Fayette
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
(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 Missouri (b) County Howard
(c) City or town Fayette
(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 Robert H. Ruff
3. (b) If veteran, name war..... 3. (c) Social security No.....

4. Sex m 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 July 27 1887
(Month) (Day) (Year)

8. AGE: Years 54 Months 10 Days 18 min.
(If less than one day)

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

10. Usual occupation.....

11. Industry of 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) (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) 7-9-42 (b) Thomas S. Denny
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day..... year 1942 hour..... minute..... M.

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

Duration

Due to.....

Due to.....

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

Major findings:
Of operations.....

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.....

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

MOTHER FATHER

SUPPLEMENTARY

