

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15655

State File No.

FILED MAY 7 1943

Primary Registration District No. 2073- R6112

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Rural, Mahoning  
(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 Mo (b) County Scott  
(c) City or town Chaffee Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 128 Cook  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Ruth Ann Woodbridge

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 Baby  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased. April 9 1943  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
1 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Ruth Woodbridge  
13. Birthplace Mayfield Bollinger Co. Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Dorothy Proctor  
15. Birthplace Chaffee Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. ne Proctor

(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 4-10-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Park Chaffee Mo

18. (a) Signature of funeral director Bisplinghoff Hubbard

(b) Address Chaffee Mo

19. (a) Apr 10-43 (b) Christa Truse  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9  
year 1943 hour 9 minute 47 P. M.

21. I hereby certify that I attended the deceased from birth  
Apr. 9 1943, to Apr. 9 1943;  
that I last saw her alive on Apr. 9 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death Premature - 6 mo.

Due to.....

Due to.....

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 Mabel M. Delesieux (M. D. or other) DO.

Address Chaffee - Mo. Date signed 4/10/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

100  
90

1325

RECEIVED

District Health Office No. 2,

District File Number 543-684

Date Filed 5-6-73

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 <sup>not</sup>.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Marnie Prepenhoff

Licensed Embalmer No. 3242

P. O. Address Chaffee

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.