

Registration District No. 1 Primary Registration District No. 3000

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

1. PLACE OF DEATH

(a) County Adair

(b) City or town Marshallville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Franklin Hotel
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community one day overnight
years, months or days)

3. (a) PRINT FULL NAME Jesse Calvin Rugg

3. (b) If veteran, name war _____

3. (c) Social Security No. 488-10-2608

4. Sex M Color or race W

5. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased April 9 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 18 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Invalid

11. Industry or business _____

12. Name Frank Rugg

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

14. Maiden name Dorothy

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

16. (a) Informant Walter M. Rugg

(b) Address Albert Lee Rugg, Box 15

17. (a) Burial (b) Date thereof 4/30/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pleasant

18. (a) Signature of funeral director Sumner Powell

(b) Address Richwood, Mo.

19. (a) 4/29/44 (b) W. J. Wagure
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Henry

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

(d) Street No. 707 S. Main
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1944 hour 9 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____.

that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Due to said treatment, but he was a diabetic

Due to Occlusion

Due to Dr. Jackson

Other conditions Mt Pleasant Iowa
(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 W. J. Sumner (M.D. or other) Coronary
Address Marshallville Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 5-44-964

Date Filed MAY 1 1944

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Fishersville, 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, fact should be so stated above.