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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38640**

FILED NOV 25 1944
301

Registration District No. _____

Primary Registration District No. **6032**

Registrar's No. **2011**

1. PLACE OF DEATH: **Ripley**

(a) County **Ripley**
(b) City or town **Doniphan - Mo. Co.**
(c) Name of hospital or institution: **Rural**
(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 **Ripley**
(c) City or town **Doniphan Rural**
(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 **William F. Ruminer**

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

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Mellie** 6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **Oct. 4 1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **1** Days **2** If less than one day _____ hr _____ min.

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

10. Usual occupation **Farming**

11. Industry or business _____

MOTHER FATHER { 12. Name **William A. Ruminer**
13. Birthplace **Ill.**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant **Mellie Ruminer**
(b) Address **Doniphan Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 7, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **oak Grove cent**

18. (a) Signature of funeral director **Blacks Montway**
(b) Address **Doniphan Mo.**

19. (a) **11-21-44** (b) **E. B. Johnston**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **6.**
year **1944** hour **9** minute **17 P.M.**

21. I hereby certify that I attended the deceased from **July 8, 1944** to **December 6, 1944**
that I last saw him alive on **December 5, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Aortic Stenosis with pulmonary insufficiency**
Due to **Hypertension**
Due to **Arteriosclerosis**

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

Major findings: Of operations **9 2 a**
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? _____

(Specify type of place) _____
23. Signature **J. E. Williams** (M. D. or other) _____
Address **Doniphan, Mo.** Date signed **11-12-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Not Embalmed....., 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.