

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

8194

State File No. _____
Registrar's No. **2028**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 16 1948
318

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-weeks
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Farrel J. Ruane
3. (b) If veteran, name war World War #1 **3. (c) Social Security** No. _____
4. Sex M. **5. Color or race** W. **6. (a) Single, widowed, married, divorced.** M.
6. (b) Name of husband or wife Hilda Ruane **6. (c) Age of husband or wife if alive** 45 years
7. Birth date of deceased May 16th., 1895
(Month) (Day) (Year)

8. AGE: Years 49 Months 9 Days 15 If less than one day hr. min.

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

10. Usual occupation Rate Clerk
11. Industry or business Mo. Pacific R.R.

12. Name Patrick Ruane
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Quirk
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hilda Ruane

(b) Address 5055 Durant Ave.

17. (a) Burial Calvary **(b) Date thereof** 3-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) MAR 2 1948 **(b) Registrar's signature** [Signature]
(Date received local registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5055 Durant Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1st., year 1948 hour 4 minute 30 p.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 Subdural Hemorrhage
of brain carcinoma of the floor
of the floor in the Hall of
room 513 at the Missouri
State Hospital on March 1st
1948 at about 9:15 a.m.

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) Accidental

(b) Date of occurrence March 1st 1948

(c) Where did injury occur? St. Louis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Hospital
(Specify type of place) (Means of injury) fall

23. Signature [Signature] (M. D. or other) _____
Address [Address] **Date signed** 3/2/48

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

MAR 20 1945

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3846 Rindell

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.