

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1945

Registration District No. 374

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6272

State File No. 10000

Registrar's No.

1. PLACE OF DEATH:

(a) County North
(b) City or town Rural Allen Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 6 yrs. (Specify whether years, months or days)
In this community 6 yrs.

3. (a) PRINT FULL NAME Emma Rhuday

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

4. Sex ♀ 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife T. L. Rhuday 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 7 1877
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business

12. Name Chris Banger
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 T. L. Rhuday
(b) Address Grant city, Mo.
17. (a) Burial (b) Date thereof 3-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grant city cemetery
18. (a) Signature of funeral director John S. Duffee
(b) Address Grant city, Mo.
19. (a) Mar. 20 1945 (b) Margie Ruchert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County North
(c) City or town Rural 113
(If outside city or town limits, write "RURAL")
(d) Street No. Grant city, Mo.
(If rural, give location)
(e) Citizen of foreign country? not (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 15
year 1945 hour 10 minute 15 A.M.
21. I hereby certify that I attended the deceased from 10-10-42
to 3-12-45
that I last saw her alive on 3-9-45
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Artery
Duration 10-10-42

Due to ✓
Due to ✓

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

Major findings ✓
Of operations no
Of autopsy 83001

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 John S. Duffee (M. D. or other)
Address Grant city, Mo. Date signed 3-16-45

(Licensed Embalmer's Statement on Reverse Side)

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Arch C. Drayton

Licensed Embalmer No. *3252*

P. O. Address *Grant City, 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.