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7-5-17-39
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31344

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 306

Primary Registration District No. 6048

Registrar's No. 244

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Peters-rural (If outside city or town limits, write "RURAL" and name of township) W.A. Neumann

(c) Name of hospital or institution: Jury

(If not in hospital or institution, write street number or location)

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

In this community 15 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Peters rural (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) no

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Ward Ruth

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Febr. 16 19 1877 (Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace: De Soto Iowa (City, town, or county) (State or foreign country)

10. Usual occupation farm laborer

11. Industry or business farming

MOTHER FATHER

12. Name unknown

13. Birthplace unknown (City, town, or county) (State or foreign country) 97

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant W. G. Schneider

(b) Address RR 1, St. Charles, MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-15-45 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove, St. Charles, MO.

18. (a) Signature of funeral director: Geo. Stiefvater

(b) Address St. Peters, MO.

19. (a) Sept 15-45 (Date received local registrar) (b) E. A. Rethley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 13th day Sept. year 1945 hour 10 minute A. M.

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

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

Immediate cause of death: Aortitis
Jury's verdict

Due to _____

Due to _____

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

Major findings: _____ Of operations: _____

Of autopsy: none

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? _____

(Specify type of place)

While at work? _____ (e) Means of injury 3

23. Signature: Margaret M. ... Date signed: _____

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

682

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number _____
Date Filed 10-8-45

NOV 5
1950

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 _____

Licensed Embalmer No. 872

P. O. Address. Chillicothe 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.