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FILED MAY 2 1946
318

1003

State File No. _____
Registrar's No. 3120

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME RUTH A. MUSE
3. (b) If veteran, name war W.W. 2
3. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased MAY 30 1913
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 10 3 hr. min.

9. Birthplace Depton MO
(City, town, or county) (State or foreign country)

10. Usual occupation NURSE U.S. ARMY

11. Industry or business RETIRED

12. Name UNKNOWN

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

14. Maiden name UNKNOWN

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

16. (a) Informant Meta E. Muse
(b) Address 7117 Michigan

17. (a) Cremation (b) Date thereof April 4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MISSOURI CEMETORY
18. (a) Signature of funeral director G. Hoffmeyer
(b) Address 7814 S. Broadway
19. (a) APP 3 1946 (b) J. F. Brudek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MICHIGAN (b) County 000
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 7117 MICHIGAN
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2
year 1946 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from March 27 1946 to Apr. 2 1946
that I last saw her alive on Apr. 2 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory obstruction + pulmonary edema
Due to Sabectomy, r.u.l.
Due to Tuberculosis, pulmonary

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Tuberculosis - bronchus
Of operations _____
Of autopsy Tuberculosis - bronchus + r.u.l.

22. If death was due to external causes, fill in the following pulmonary edema
(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)
(c) Means of injury _____
23. Signature JR Bradley (M. D. or other) _____
Address Barnes Hospital Date signed 4/3/46

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

MOTHER FATHER

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..... *Linn C. Hoffmeister*

Licensed Embalmer No..... *3871*

P. O. Address..... *7814 S. Broadway*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. May3125Registration District No. 318Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(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)3. (a) PRINT
FULL NAME Ruth A. Muse

3. (b) If veteran,
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex
- F
5. Color or
-
- race
- W
6. (a) Single, widowed, married,
-
- divorced
- S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
-
- alive _____

7. Birth date of deceased
- May 30 1905
-
- (Month) (Day) (Year)

8. AGE: Years Months Days (Less than one day)
-
- 32
- 10
- 10
- hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____
 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 _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

- (b) Address _____

19. (a) _____ (b)
- J. F. Bredek
-
- (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 _____ (M. D. or other)
-
- Date signed _____

MAY 7 1946

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

SUPPLEMENTARY

