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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9603**

Registration District No. **147**

Primary Registration District No. **5569**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **JACKSON**
(b) City or town **KANSAS CITY** *RURAL*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
59th & SMITH ROAD 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community **45 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON 48**
(c) City or town **KEES SUMMIT, MO 3 0**
(If outside city or town limits, write "RURAL")
(d) Street No. **59th & SMITH ROAD 0**
(If rural, give location) **0**
(e) Citizen of foreign country? **YES** (Yes or No)
If yes, name country **GERMANY**

3. (a) PRINT FULL NAME **CHARLES ARTHUR RUCKDESCHER**

3. (b) If veteran, name war **NO**
3. (c) Social Security No. **NONE**

4. Sex **MALES** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **MRS. BESSIE RUCKDESCHER**
6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **Nov-5-1879**
(Month) (Day) (Year)

8. AGE: Years **67** Months **2** Days **26**
If less than one day _____ hr. _____ min.

9. Birthplace **LIVICHBURG GERMANY 4**
(City, town, or county) (State or foreign country)?

10. Usual occupation **FARMER**

11. Industry or business _____

MOTHER FATHER } 12. Name **JOHN B. RUCKDESCHER 4**

13. Birthplace **GERMANY 1**

14. Maiden name **MARIE KRIENT** (State or foreign country)

15. Birthplace **GERMANY 4** (City, town, or county) (State or foreign country)?

16. (a) Informant **MRS. BESSIE RUCKDESCHER**

(b) Address **R.P. 3, KEES SUMMIT, MO**

17. (a) **BURIAL** (b) Date thereof **MAR. 4, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **FLORAL HILLS MEM. CH. Newcomer's home**

18. (a) Signature of funeral director **W. H. Newcomer's home**

(b) Address **1401 BRUSH CREEK BLVD.**

19. (a) **MAR 3, 47** (b) **W. H. Newcomer**
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **MARCH** day **15**
year **1947** hour **3** minute **45 H. M.**

21. I hereby certify that I attended the deceased from **Feb. 29/47**
to **MAR. 1 1947**
that I last saw him alive on **Feb. 28 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death **Ischemic thrombosis**

Due to **undetermined**

Due to **patent duct ectasia of prostate gland.**

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

Major findings:
Of operations **none B**

Of autopsy **none 51 B**

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 **W. H. Newcomer** (M. D. or other) **0**

Address **1303 N. Main St. St. Louis, Mo.** Date signed **3/11/47**

MEDICAL CERTIFICATION

Duration

9 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

137

(Licensed Embalmer's Statement on Reverse Side)

J. C. PRO.

1505
10:30-5

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 *Earl Rapp*
Licensed Embalmer No. *3458*
P. O. Address. *K.C. 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.

Registration District No. 147

Primary Registration District No. SS69

1. PLACE OF DEATH:

(a) County JACKSON
(b) City or town RURAL-BROOKING TWP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
59th & Smith Road
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community _____ (Specify whether
years, months or days)

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 _____

3. (a) PRINT FULL NAME Charles A. Ruckdeschel

3. (b) If veteran, name war _____ 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 _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased no
(Month) (Day) (Year)

8. AGE: Years Months Days (if less than one day) min.

9. Birthplace Germany
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1947 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. _____
Duration _____
Immediate cause of death _____

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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

9603