

S. No. 2
11-10-39
7-5-17-39
17-21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18498

State File No. _____

FILED JUN 9 1947

Registrar's No. 87

Registration District No. 310

Primary Registration District No. 3058

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

1. PLACE OF DEATH:

(a) County ST. CHARLES
(b) City or town "
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 HOURS
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME EDWARD A. RUEFFER

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

4. Sex MC 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: JAN 9 1870
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 16 If less than one day hr. _____ min. _____

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

10. Usual occupation LABORER

11. Industry or business _____

MOTHER FATHER { 12. Name ADAM RUEFFER
13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name NOT KNOWN
15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant MIS. ANNIE RUEFFER

(b) Address COTTLEVILLE MO

17. (a) BURIAL (b) Date thereof 5 27 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation COTTLEVILLE MO.

18. (a) Signature of funeral director Eckert

(b) Address 2225 N. 3rd St. St. Louis, Mo.

19. (a) 5-28-47 (b) Jannie Hamilton
(Date received local registrar) (Registrar's signature) 284

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST. CHARLES
(c) City or town ST. CHARLES
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 25
year 1947 hour 1 minute AM

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: chronic myocarditis + glomerular nephritis
Due to generalized arteriosclerosis
Due to _____

Duration

10 days

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 25 May
(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 0

23. Signature L. B. Fallon MD (M. D. or other)
Address Fallon Mo Date signed 26 May 47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 4 1947

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 E. K. [Signature]
Licensed Embalmer No. 822
P. O. Address Dallas 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, above space should be left blank:

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JuneRegistration District No. 310Primary Registration District No. 2058Registrar's No. 87

1. PLACE OF DEATH:

(a) County St Charles
 (b) City or town St Charles
 (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 NAMEEdward A. Rueffer3. (b) If veteran,
name war3. (c) Social Security
No.4. Sex m 5. Color or
race w6. (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

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

27

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country) MO

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)

May 28 / 47
(Date received local registrar)

(b)

Francis Houston
(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 June
year 1947 hour 12 minute 15 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) (c) Means of injury

23. Signature (M. D. or other)

Address Date signed

6/11/47

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

MOTHER FATHER

18498