

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1051

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Jennings, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Elms Convelesing Home** 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 Months**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Gustave Ruff**
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 **Widowed**
6. (b) Name of husband or wife **Anna** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 8, 1856**
(Month) (Day) (Year)

8. AGE: Years **91** Months **1** Days **14**
If less than one day _____ hr. _____ min.

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired- Stone Cutter**

11. Industry or business _____

MOTHER FATHER { 12. Name **Ignatius Ruff**
13. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)
14. Maiden name **Hetwig Schweikert**
15. Birthplace **Germany** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **Othelia Schroer**
(b) Address **5615 Milentz Ave.**

17. (a) **Burial** (b) Date thereof **5/24/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter & Paul Cemetery**
18. (a) Signature of funeral director **Hebken Sons**
2650 Gravois Ave.

(b) Address _____
19. (a) **3-24-47** (b) **Cecil R. Slap / 100**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Louis** 96
(c) City or town **Ruralia** 0
(If outside city or town limits, write "RURAL")
(d) Street No. **2520 Mc Laran, Jennings, Mo.** 0
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** 22, 1947
year hour **9:30** minute _____ P M.

21. I hereby certify that I attended the deceased from **Feb 21**
1946 to **May 22** 1947
that I last saw him alive on **May 22** 1947
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis** 2yrs?
Duration

Due to _____ 93d
Due to _____

Other conditions **Arteriosclerosis** 10yrs?
(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) (c) Means of injury _____

23. Signature **Eugene P. Arnold** (M. D. or other) **MD.**
Address **1449 Mc Laran** Date signed **5/23/47**

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 Robert F. Gebken
.....
Licensed Embalmer No. 4144
P. O. Address 2630 Gravois Ave

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.