

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35230**  
**9181**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3555 Longfellow Bl.</b>				d. STREET ADDRESS (If rural, give location) <b>3555 Longfellow Bl.</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Ruby</b>		b. (Middle) <b>Robb</b>		c. (Last) <b>Hoban</b>	
4. DATE OF DEATH		(Month) <b>10</b>		(Day) <b>20</b>		(Year) <b>1949</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 12, 1882</b>	
9. AGE (In years last birthday) <b>67</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <b>Marian Davis</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Wright</b>		14. NAME OF HUSBAND OR WIFE <b>James J. Hoban</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>James J. Hoban 3555 Hongfellow Bl.</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral apoplexy</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Chronic Interstitial Nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____		19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY) _____ (STATE) <b>12/10</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>542X</b>			
22. I hereby certify that I attended the deceased from <b>April 18, 1949</b> to <b>October 19, 1949</b> , that I last saw the deceased alive on <b>Oct 14, 1949</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Robert J. Glaser M.D.</b> (Degree or title)				23b. ADDRESS <b>506 Olive St.</b>		23c. DATE SIGNED <b>10-21-49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-24-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>East St. Louis, Illinois</b>	
DATE REC'D BY LOCAL REG. <b>OCT 22 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Sasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Weick Bro. Und. Co. 2201 S. Grand Bldg.</b>			

WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*James R. Dunn*

Licensed Embalmer No. 4527

P. O. Address 2201 S Grand St

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.