Health, Welfare Public Service

300 -57

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012244
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2170

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN St. Louis, Mo. — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Lukes Hosp. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4068a Shaw — Reside on Farm Yes ☐ No ☐

32 21790

3. NAME OF DECEASED (Type or print) First: Lillian	Middle: Ruga	Last:	4. DATE OF DEATH Month Day Year: Feb. 20, 1958	
5. SEX: female	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Jul. 4, 1903	9. AGE (In years last birthday): 54 — 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): Stenographer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME: Gottlieb Rist	13b. MOTHER'S MAIDEN NAME: Unk.	14. NAME OF HUSBAND OR WIFE: Elmer Ruga		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none	16. SOCIAL SECURITY NO.	17. INFORMANT: Lorraine Norris	Address	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic Cor Pulmonale	2 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic Bronchiectasis	5 yrs.
DUE TO (c)	526x	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from November, 1957, to Feb. 20, 1958 and last saw her alive on Feb. 20, 1958. Death occurred at 1030 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William A. Ruge M.D.	22b. ADDRESS: 3720 Washington, St. Louis 8, Mo.	22c. DATE SIGNED: 2/22/58

23a. BURIAL, CREMATION, REMOVAL (Specify): removal	23b. DATE: 2-24-58	23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.	23d. LOCATION (City, town, or county) (State): Lemay 23, Mo.
24. FUNERAL DIRECTOR: Southern Funeral Home	ADDRESS: 6322 S. Grand, St. Louis, Mo.	25. DATE RECD. BY LOCAL REG.: FEB 24 '58	26. REGISTRAR'S SIGNATURE: J. Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

mB

All diseases in Part I must be causally related.

Mr. Wm. A. Tubbs
3720 Washington
Beaumont
Je 1-8990
130 6-3

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 .....
Signature of Student Embalmer

Signed David Van Hanson

Licensed Embalmer No. 1242.

P. O. Address St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.