

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027403
STATE FILE NUMBER

FILED AUG 11 1958

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 7508

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>7</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DI 4249 Clay Ave</u>		d. STREET ADDRESS (If outside, give location) <u>2109 4249 Clay Ave</u>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATIE M. RUHRWIEM</u>			4. DATE OF DEATH Month Day Year <u>7-30-1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1869</u>
9. AGE (In years last birthday) <u>88</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	11. BIRTHPLACE (City and state or country) <u>Creve Cour. Mo</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>Henry Schoenhof</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Rober</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Viola Kruse- 4249 Clay Ave</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion of Aorta</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u>			<u>25 years</u>
DUE TO (c) <u>Hypertension</u>			<u>? years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Myocardial infarction - multiple Pulmonary embolism</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>4201</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
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 <u>5-26-57</u> to <u>7-30-58</u> and last saw her alive on <u>7-30-58</u> Death occurred at <u>7-30-58 8:45 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John V Lawrence MD</u>		22b. ADDRESS <u>3720 Washington Ave St. Louis Mo</u>	22c. DATE SIGNED <u>8-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8-2-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Edw Koch + Son - 3516 N. 14th</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 1 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith MD</u> <u>mjs</u>

(Licensed Embalmer's Statement on Reverse Side)

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 *Herbert J. Cox, Jr.*

Licensed Embalmer No. *4800*

P. O. Address *Richwood, R. 2, 7*

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.