

pt. Health,
, & Welfare
S. Public
lth Service

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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038172

STATE FILE NUMBER

XC

SL 17926

318

1003

FILED OCT 17 1958

Registration District No.

Primary Registration District No.

Registrar's No. 9539

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N Grand St Louis Mo		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Granite City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
35 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Vets Admin Hospital		Length of stay in lb 10 Days	d. STREET ADDRESS 3320 Lydia Lane 32 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Arthur E Ruff			4. DATE OF DEATH Month Day Year Oct 3 1958
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/10
9. AGE (In years last birthday) 40	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) Salesman		10b. KIND OF BUSINESS OR INDUSTRY KENT-REBER	11. BIRTHPLACE (City and state or country) Dayton, Ohio /
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Ruff	13b. MOTHER'S MAIDEN NAME Grace M. Lasure
14. NAME OF HUSBAND OR WIFE Dorothy Ruff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If Yes, give year or dates of service) Yes VA II	16. SOCIAL SECURITY NO. - - - - -
17. INFORMANT Address VA Hosp Records 915 N Grand St Louis Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC LYMPHOYTIC LEUKEMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) - - - - - DUE TO (c) - - - - - 204.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) - - - - -			INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. attended the deceased from 9/23/58 to 10/3/58 and last saw him alive on 10/3/58 Death occurred at 5:25 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Frank A. Riddick Frank A. Riddick		M.D. 0 M.D.	22b. ADDRESS VAH, St. Louis, Mo
22c. DATE SIGNED 10/3/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-3-1958	23c. NAME OF CEMETERY OR CREMATORY SUNSET HILL CEMETERY	23d. LOCATION (City, town, or county) (State) EDWARDSVILLE, ILLINOIS
24. FUNERAL DIRECTOR Francis M... Granite City		25. DATE RECD. BY LOCAL REG. OCT 6 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. m. f. a.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Charles E. Mac*

Licensed Embalmer No. *2988*

P. O. Address *Granite City*

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.