

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001826

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 5592 Registrar's No. 6

300
-57

1. PLACE OF DEATH
 a. COUNTY Jefferson
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joachim Twp. Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hiways A & Z Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY Jefferson
 c. CITY OR TOWN Mapaville Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) Hiways A & Z Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last
 Ruby F. Gruber
4. DATE OF DEATH Month Day Year
 Jan. 14 1959

5. SEX Female **6. COLOR OR RACE** White **7. MARRIED** NEVER MARRIED
 WIDOWED DIVORCED
8. DATE OF BIRTH Dec. 4, 1901 **9. AGE** (In years last birthday) 57 **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) Housewife **10b. KIND OF BUSINESS OR INDUSTRY** Own Home **11. BIRTHPLACE** (City and state or country) St. Louis, Mo. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME Harvey J. Hartwell **13b. MOTHER'S MAIDEN NAME** Rose M. Smith **14. NAME OF HUSBAND OR WIFE** William C. Gruber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No **16. SOCIAL SECURITY NO.** **17. INFORMANT** William C. Gruber, Mapaville, Missouri Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) CORONARY Occlus ion
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____
 DUE TO (c) _____
 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.) 4201

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

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 7:45 AM and last saw her alive on _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James C. Felton M.D. Coronary Doctor **22b. ADDRESS** **22c. DATE SIGNED** 1/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal **23b. DATE** Jan. 16, 1959 **23c. NAME OF CEMETERY OR CREMATORY** Zion Cemetery **23d. LOCATION** (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR Vinyard Fun'l Homes, Inc., Festus, Mo. ADDRESS **25. DATE RECD. BY LOCAL REG.** 1-14-59 **26. REGISTRAR'S SIGNATURE** James A. DeJido

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 22 1959

FEB 3 1959

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 *Frederick B. Simpson*

Licensed Embalmer No. 14946

P. O. Address Feetonsville

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.