

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-031203
STATE FILE NUMBER

FILED VS SEP 14 1959

Registration District No. 337 Primary Registration District No. _____ Registrar's No. 72

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Shelby</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shelby</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Shelbyville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Shelbyville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FAMILY HOME</u>		Length of stay in lb <u>4 1/2 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>1020 SHELBYVILLE, MO.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>HIRAM BANNING RUTH</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 8 1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1866</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER-FARMER'S ELEVATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>0</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Phillip Ruth</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN KENNEL</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</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.	17. INFORMANT <u>Bob Ruth</u>	Address <u>MACON, MO.</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>Arterio Sclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4560</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 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 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>June 22 1959</u> , to <u>Sept 8 1959</u> and last saw him alive on <u>Sept 6 1959</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>R. G. ... M.D.</u>		(Degree or title) <u>0</u>	22b. ADDRESS <u>Shelbyville Mo</u>		22c. DATE SIGNED <u>9-9-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT 10, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EMDEN BAPTIST</u>	23d. LOCATION (City, town, or county) (State) <u>EMDEN MISSOURI</u>		
24. FUNERAL DIRECTOR <u>GREENING FUNERAL HOME</u>		ADDRESS <u>Shelbyville</u>	25. DATE RECD. BY LOCAL REG. <u>9-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Ada Garrison</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
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.

SEP 17 1969

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 V. Greening*

Licensed Embalmer No. *4625*

P. O. Address *Clarence 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.