

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038032

FILED VS NOV 3 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9493**

UNDECEASED

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital | | d. STREET ADDRESS (If outside, give location) 5875 Elmbank Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|--|----------------------------------|---|---|--|--------------------------------|
| 3. NAME OF DECEASED (Type or print) First Charles Middle EDWARD Last Ruell | | | 4. DATE OF DEATH Month Oct Day 15 Year 1959 | | |
| 5. SEX MALE | 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 8-6-1883 | 9. AGE (last birthday) 76 | IF UNDER 1 YEAR Months Days |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | 10b. KIND OF BUSINESS OR INDUSTRY Buckley Co. | 11. BIRTHPLACE (City and state or country) Mt. Carmel, Illinois | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME Frank Ruell | | 13b. MOTHER'S MAIDEN NAME Esther Hunt | | 14. NAME OF HUSBAND OR WIFE Christine Ruell | |
| 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. unknown | | 17. INFORMANT Hazel B. Hackey 5875 Elmbank | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 181.0 | | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
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|---|---|--|--|--|--|
| 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. _____ | | | | | |

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|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <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 **May 1959** to **Oct 15 1959** and last saw him alive on **10/15/59**
Death occurred at **11:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE W. F. Melick, M.D. | 22b. ADDRESS 372 O Washington | 22c. DATE SIGNED 10/16/59 |
|---|---|-------------------------------------|

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|---|------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | 23b. DATE 10-19-59 | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery | 23d. LOCATION (City, town, or county) St. Louis Co., Mo. |
|---|------------------------------|---|--|

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| 24. FUNERAL DIRECTOR Bensiek-Hiehaus | ADDRESS 1431N. Union Blvd. | 25. DATE RECD. BY LOCAL REG. OCT 16 '59 | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

WFB

113077 2/17/04

[Faint handwritten text]

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 *[Handwritten Signature]*

Licensed Embalmer No. 467

P. O. Address *[Handwritten Address]*

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.