

FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038033

FILED VS OCT 23 1959

2 9489

STATE FILE NUMBER

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

UNRECORDED

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | | Length of stay in 1b | | 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 Enroute City Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 4028 Walsh St. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First CLARENCE Middle L. Last RUHR | | | | 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 11-29-1903 | 9. AGE (last birthday) 55 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Classified Beer Bottler | | 10b. KIND OF BUSINESS OR INDUSTRY Falstaff Brewing Co. | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Frank Ruhr | | | 13b. MOTHER'S MAIDEN NAME Jenny Lind | | | 14. NAME OF HUSBAND OR WIFE Rose Ruhr | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.#2 | | 16. SOCIAL SECURITY NO. 497-07-2635 | | 17. INFORMANT Address Rose Ruhr 4028 Walsh St. | | | |
| 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 Occlusion | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Arteriosclerotic heart disease | | | | | | | 7 years |
| DUE TO (c) 420.0 | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchiectasis | | | | | 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 | | |
| 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 _____ a.m. _____ p.m. | | Month, Day, Year | | | | | |
| 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 July 1952 to 15 Oct 59 and last saw him alive on 15 Oct 59 Death occurred at 7:30 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22. SIGNATURE (Degree or title) Frank Neesen M.D. | | | | 22b. ADDRESS 4209 S Kingshighway | | 22c. DATE SIGNED 16 Oct 59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 10-19-1959 | 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo. | | |
| 24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S.Kingshighway | | | | 25. DATE RECD. BY LOCAL REG. OCT 16 '59 | | 26. REGISTRAR'S SIGNATURE Loan Smith, M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Edwin A. McAnulty

Licensed Embalmer No. 3024

P. O. 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.