

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS JAN 25 1960

-60-004686

Registration District No. 224 Primary Registration District No. 3072 Registrar's No. 9 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>10 days</b>	c. CITY OR TOWN <b>Marshall</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fitzgibbon hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>717 East Eastwood</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>E.</b> Last <b>Ruckel</b>			4. DATE OF DEATH Month <b>January</b> Day <b>22nd</b> Year <b>1960</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	11. BIRTHPLACE (City and state or country) <b>Miami, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Henry Ruckel</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Huffman</b>	14. NAME OF HUSBAND OR WIFE <b>Angie W. Ruckel</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World war I.</b>	16. SOCIAL SECURITY NO. <b>487-01-4434</b>	17. INFORMANT Address <b>Mrs Raynond E. Ruckel, Marshall Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
DUE TO (b) <b>Cholelithiasis Heart Disease</b>		<b>Unknown</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)		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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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
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21. I attended the deceased from **Sept 1958** to **Jan 22, 1960** and last saw him alive on **Jan 22, 1960**  
 Death occurred at **8-30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Robert W. Blalock</b>	22b. ADDRESS <b>Marshall, Missouri</b>	22c. DATE SIGNED <b>1-26-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>I-24-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miami cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Miami Missouri</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Cambell-Lewis, Marshall Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>1-22-60</b>	26. REGISTRAR'S SIGNATURE <b>Cecil J. Reed</b>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

FEB 10 1960

FEB 1

JAN 27 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

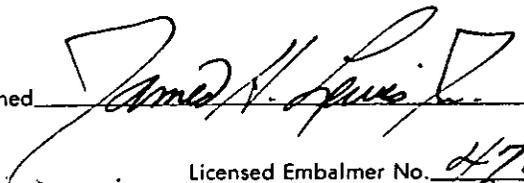
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 4709

P. O. Address Marshall, W

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.