LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

33458

. PLACE OF DEATH
County St Louis — Registration District No. 78 — File No.
Township Bonhomme — Primary Registration District No. 6031 — Registered No. 168
City (No. St. Ward)

. FULL NAME Bryan W. Rudder
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
ength of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	W.	Married

. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Irene Rudder

DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 5th 1896

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	25	9	29	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fenton Mo

10. NAME OF FATHER John F Rudder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Fenton

12. MAIDEN NAME OF MOTHER Lou Billups

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Union Mo Franklin Co

INFORMANT John F. Rudder
(Address) Fenton Mo

FILED 12/10 1921 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1921

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1920, to Dec 4th, 1921 that I last saw him alive on Dec 4, 1921, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular disease heart
(duration) 1 yrs. 11 mos. ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? X Ray
(Signed) M. Dalton, M. D
, 19 (Address) Fenton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Park Hill Cemetery — DATE OF BURIAL Dec 6 1921

20. UNDERTAKER John G Koch — ADDRESS Fenton Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred , yrs. mos. ds. How long in U.S., if of foreign birth? , yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH, (MONTH, DAY AND YEAR) 19

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I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19....
that I last saw h..... alive on....., 19....., and t
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, stat (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, o HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS