

WAY 27 1927

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

Do not use this space.
J. O. James
11431

1. PLACE OF DEATH
County Greene Registration District No. 318
Township Springfield Primary Registration District No. 290
City Springfield (No. 1607) in Campbell St. _____ (Ward) _____
2. FULL NAME D. Wesley J. Ruyle
(a) Residence No. 1607 N. Campbell 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 8 2 1/2

8. 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 _____
9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Isidon Ruyle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Berd Winton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT T. A. Ruyle
(Address) Springfield, Mo.
15. FILED 4/11 1927 Octford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 10 1927
17. I HEREBY CERTIFY, That I attended deceased from April 10, 1927, to April 10, 1927, that I last saw him alive on April 10, 1927, and that death occurred, on the date stated above, at 9 a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Influenza
(duration) _____ yrs. mos. 10 ds.
CONTRIBUTORY Myocarditis
(SECONDARY) (duration) 4 yrs. mos. ds.

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) Joseph O. James, M. D.
(Address) 704 Wood
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL East Lawn Cemetery DATE OF BURIAL April 12 1927

20. UNDERTAKER W. S. Kingner & Co ADDRESS Springfield, Mo.

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.

