

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis Mo.*

Registration District No. **791**
Primary Registration District No. **100**
(No. *De Paul Hospital*)

File No. **34458**
Registered No. **9817**
St. Ward)

2. FULL NAME

George X Ruegger
(a) Residence, No. *4460 - Gibson Ave* St. *15* Ward.
(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>June 26 - 1867</i>		
7. AGE	YEARS <i>63</i>	MONTHS <i>3</i>
	DAYS <i>17</i>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <i>Insurance Broker</i> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <i>Ills.</i> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <i>X Ruegger</i>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Switzerland</i>	
	12. MAIDEN NAME OF MOTHER <i>Not known</i>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Switzerland</i>	
14. INFORMANT <i>Mary Ruegger</i> (Address) <i>4460 - Gibson Ave</i>		
15. FILED <i>Max Starkoff</i> 19.....		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 13th 1930*

17. I HEREBY CERTIFY that I attended deceased from *Sept 15th 1930* to *Oct 17th 1930* and that I last saw him alive on *Oct 17th 1930*, and that death occurred, on the date stated above, at *7:10 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
*Nephrosclerosis
(Left) malignant
Bilateral Kidney
Metastases - Lungs*

CONTRIBUTORY (SECONDARY) *5* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? *No* DATE OF
WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *K. J. Brady* M. D.
112 1930 (Address) *Union Club*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <i>Bak. Grove</i>	DATE OF BURIAL <i>Oct 15 1930</i>
20. UNDERTAKER <i>Key Leidner Und. Co.</i>	ADDRESS <i>1417 N. Market St.</i>

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.

