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7-39
K23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **33832**
Registrar's No. **8529**

Registration District No. **791** Primary Registration District No. **1003**

PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community Birth
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis 20
(If outside city or town limits, write "RURAL")
(d) Street No. 3818a N. 23rd St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Emma Ruff
3. (b) If veteran, name was None 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 14th
year 1940 hour 5:40 AM minute _____ M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Arthur T. Ruff 6. (c) Age of husband or wife if alive Deceased years
7. Birth date of deceased May 4, 1872
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 28 1940 to Oct 14 1940
that I last saw her alive on Oct 13 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
68 5 10 hr. _____ min.

Immediate cause of death Broncho Pneumonia Duration 1 day

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

Due to Carcinoma of Rt ovary Primary small and large intestine
Due to Chronic cyst of the ovary

10. Usual occupation At home

Other conditions none
(Include pregnancy within 3 months of death)

MOTHER FATHER
11. Industry or business _____
12. Name Not known
13. Birthplace Germany
(City, town, or county) (State or foreign country)
14. Maiden name Not known
15. Birthplace Germany
(City, town, or county) (State or foreign country)

Major findings: 49
Of operations X
Of autopsy Same as above
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr Elmer Ruff
(b) Address 3818a N. 23rd St.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence X

17. (a) Cremation (b) Date thereof 10/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? X
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

(c) Place: burial or cremation Valhalla Crematory
(a) Signature of funeral director Math Hermann & Son
(b) Address 2161 East Fair Ave

While at work? X (Specify type of place) (e) Means of injury X

19. (a) OCT 15 1940 (b) J. F. Bruck
(Date received local registrar) (Registrar's Signature)

23. Signature Dr. William J. Hinski (M. D. or other) MD
Address 3500 N. Grand Date signed 10/14/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *William G. Buchholz*

Licensed Embalmer No. *2110 5*

P. O. Address *St. Louis 71*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.