

No. 2
4-13-40
5-17-39
I X23159

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH **3**

(a) County **BUCHANAN**

(b) City or town **ST. JOSEPH**

(c) Name of hospital or institution: **STATE HOSPITAL No. 2**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **6 mos. 1 mo. 17 ds.**
(Specify whether In this community **same as above** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Andrew**

(c) City or town **Savannah**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **Wallace C. Rue**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **none**

20. DATE OF DEATH: Month **Dec.** day **17** year **1940** hour **12-45** minute **P.M.**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Beulah** 6. (c) Age of husband or wife if alive **48** years

7. Birth date of deceased **June 22 1892**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct. 31 1939** to **Dec. 17 1940**, that I last saw him alive on **Dec. 17 1940** and that death occurred on the date and hour stated above.

8. AGE: Years **53** Months **5** Days **25** If less than one day _____ hr. _____ min.

Immediate cause of death **Conussions - sudden** Duration **9 years**

9. Birthplace **Freehold N.J.**
(City, town, or county) (State or foreign country)

Due to **brain disease** **Cardio-renal decompensation**

Due to **cardiac hypertrophy**

10. Usual occupation **groc. salesman**

Other conditions (Include pregnancy within 3 months of death) **9/10**

11. Industry or business _____

Major findings: Of operations _____ Of autopsy **Corndiac hypertrophy - partial coronary occlusion cyclic degeneration frontal lobe - brain**

MOTHER FATHER { 12. Name **Andrew Eckert**

13. Birthplace **N.J.** (State or foreign country)

14. Maiden name **Mary: Chen**

15. Birthplace **N.J.** (City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically. **Cardiac hypertrophy - partial coronary occlusion cyclic degeneration frontal lobe - brain**

16. (a) Informant **Mrs. Beulah Rue**

(b) Address **607 1/2 E. 11th, St. Joseph**

22. If death was due to external causes, fill in the following:

17. (a) **Burial** (b) Date thereof **12-20-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Place: burial or cremation **Savannah**

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **85**

18. (a) Signature of funeral director **E. B. Breit**

(b) Address **Savannah mo**

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

19. (a) **Dec 19 1940** (b) **Andrew Eckert**
(Date received local registrar) (Registrar's signature)

23. Signature **T. J. O'Dell** (M. D. or other) _____
Address **St. Joseph** Date signed **12/18/40**

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

E. C. Breit

Licensed Embalmer No. *2650*

P. O. Address

Savannah Ga

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