

FILED FEB 10 1947 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 hrs.
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL.")

(d) Street No. 5465 Ashland Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Hildegarde L. Ruskaup

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Christian C. Ruskaup

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased March 27th, 1894
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25th
year 1947 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from 1-1-46
_____, 19____, to 1-25-47, 19____;

that I last saw h_____ alive on 1-24-47, 19____,
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>9</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death malignant cyst adenoma of ovary

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

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

10. Usual occupation Housewife

Major findings: as above
metastasis in liver & peritoneum

Of autopsy _____

Duration _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Theodore A. Meitz

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Margaretha Hoffmann
(City, town, or county) (State or foreign country)

15. Birthplace Wisconsin
(City, town, or county) (State or foreign country)

16. (a) Informant Christian C. Ruskaup

(b) Address 5465 Ashland Ave.

17. (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Kraeger-Voss, Inc.

(b) Address 3402 N. Kingshighway

19. (a) JAN 27 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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

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

(b) Date of occurrence _____

(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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Wm. J. Gallagher (M.D. 36320)

Address 674 N. Grand, St. Louis Date signed 1-27-47

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

MOTHER FATHER

Miss

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..... *John J. Desimone*
Licensed Embalmer No..... *4194*
P. O. Address.....

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.