

No. 300
10. 48

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 445

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY <i>Callaway</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY <i>Pettis</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Fulton</i>	c. LENGTH OF STAY (In this place) <i>4 yrs 8 months</i>	c. CITY (If outside corporate limits, write RURAL and give township) <i>Sedalia</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>State Hosp #12</i>		d. STREET ADDRESS (If rural, give location) <i>400 N. Houston St.</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>Ruby</i> b. (Middle) _____ c. (Last) <i>Rucker</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 11, 1949</i>
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5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never married</i>	8. DATE OF BIRTH <i>April 9, 1908</i>	9. AGE (In years last birthday) <i>40</i> IF UNDER 1 YEAR Months <i>7</i> Days <i>2</i> IF UNDER 12 HRS. Hours <i>2</i> Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <i>Housework</i>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <i>Pettis Mo</i>	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME <i>Albert Smith</i>	13b. MOTHER'S MAIDEN NAME <i>Betha Rivers</i>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>Dr</i>	17. INFORMANT'S SIGNATURE OR NAME <i>State Hosp #1 Records</i>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Suffocation</i>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Bed sheet being held over head by another patient</i> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Coroner was called and gave this decision 2:2</i>			

19a. DATE OF OPERATION <i>None</i>	19b. MAJOR FINDINGS OF OPERATION <i>998-</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>Homicide in hospital</i>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>in hospital</i>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Fulton Callaway Mo</i>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Jan 11, 1949 2:20</i>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Sheet held over face by fellow patient</i>
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22. I hereby certify that I attended the deceased from *April 30, 1946*, to *Jan 11, 1949*, that I last saw the deceased alive on *Jan 10, 1949*, and that death occurred at *8:44 a.m.* from the causes and on the date stated above.

23a. SIGNATURE <i>Wm. J. Greer M.D.</i>	(Degree or title)	23b. ADDRESS <i>State Hosp #1</i>	23c. DATE SIGNED <i>Jan 10, 1949</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24b. DATE <i>1-14-49</i>	24c. NAME OF CEMETERY OR CREMATORY <i>u of mo</i>	24d. LOCATION (City, town, or county) (State) <i>Columbia Mo</i>
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DATE REC'D BY LOCAL REG. <i>Jan 14, 1949</i>	REGISTRAR'S SIGNATURE <i>Joan Morsinkhoff</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>J. O. Roberts</i>	ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

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

14
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RECEIVED
District Health Officer No. 9,
District File Number
Date Filed
JAN 18 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

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.