

FILED MAR 8 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 4479

BIRTH NO. _____		REG. DIST. NO. <u>119</u>		PRIMARY REG. DIST. NO. <u>4193</u>		Registrar's No. <u>2</u>	
1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>Gasconade</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann, Mo.</u>		c. LENGTH OF STAY (In this place) <u>0</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hermann</u>		37	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Workmann Hospital</u> <u>0</u>				d. STREET ADDRESS (If rural, give location) <u>Market St.</u> <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>		b. (Middle) <u>August</u>		c. (Last) <u>Ruediger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7, 1949</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec. 25, 1881</u>	
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Shoe Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Hermann, Mo.</u> <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>August Ruediger</u>		13b. MOTHER'S MAIDEN NAME <u>Emily Bock</u>		14. NAME OF HUSBAND OR WIFE <u>Adele Ruediger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY <u>488-05-5853</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Adele Ruediger Hermann, Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Contusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>C O I 2 if</u> <u>6 25</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Comminuted fract rt Tibia fibula</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREET</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Hermann Gasconade Mo. 37</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>2 2 49 P m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>ON HIGHWAY STRUCK BY AUTO WHILE WALKING</u>			
22. I hereby certify that I attended the deceased from <u>Feb 2, 1949</u> , to <u>Feb. 7, 1949</u> , that I last saw the deceased alive on <u>Feb 7, 1949</u> , and that death occurred at <u>7 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Cavel T. Shaw, M.D.</u> <u>0</u>				23b. ADDRESS <u>Hermann, Mo</u>		23c. DATE SIGNED <u>2-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 9, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hermann, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2/9/49</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Hermann, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

37
1
0

3-7-49
DISTRICT HEALTH OFFICER NO. 9
RECEIVED

JUL 25 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 me

Student Embalmer No. _____

working under my personal supervision.

Signed [Signature]

Signed _____
Student Embalmer

Licensed Embalmer No. 2044

P. O. Address Herman n. Mo.

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.