

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4132

BIRTH NO. _____ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Cape Gir.</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. LENGTH OF STAY (in this place) <u>2 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>		0160
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cape Osteopathic Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>1 mile East Fruitland</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carl</u> b. (Middle) <u>William</u> c. (Last) <u>Ruff</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 8, 1950</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>	8. DATE OF BIRTH <u>Nov. 9, 1878</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Near Fruitland, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Geo. W. Ruff</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT'S SIGNATURE OR NAME <u>Dr. J. H. Ruff</u>		ADDRESS <u>Cape Girardeau, Mo.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Urosepsis</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Parasitic Urinary Cystitis and Ascending Infection.</u> DUE TO (c) <u>Prostatic Hypertrophy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>610X</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Feb. 7, 1950</u> , to <u>Feb. 8, 1950</u> , that I last saw the deceased alive on <u>Feb. 8, 1950</u> , and that death occurred at <u>6:05 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>M. Newell</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>105 S. Spanish Cape Girardeau, Mo.</u>		23c. DATE SIGNED <u>Feb. 10, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 9, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shilo</u>	24d. LOCATION (City, town, or county) (State) <u>W. Jackson Mo.</u>	
DATE REC'D BY LOCAL REG. <u>2-15-1950</u>		REGISTRAR'S SIGNATURE <u>C. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Krauscraft</u> ADDRESS <u>Jackson, Mo.</u>	

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

RECEIVED

FEB 20 1950

DISTRICT HEALTH OFFICE No. 4

File No. 250-239

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.

Student
Student Embalmer

Signed *Gene C. Cavanaugh*

Licensed Embalmer No. *4397*

P. O. Address *Perkins, 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.