No. 300
10.48

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29150

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2878

1. PLACE OF DEATH
a. COUNTY: St Louis county
b. CITY OR TOWN: Ballwin Mo
c. LENGTH OF STAY (in this place): 23 yrs 7 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION: Pine Crest Home 9 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2239
d. STREET ADDRESS (If rural, give location): Formerly 2003 Menard

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle): Dorothy
c. (Last): Ruppel

4. DATE OF DEATH (Month) (Day) (Year): 8-9-51

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 13, 1876
9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Johann Wiedmann
13b. MOTHER'S MAIDEN NAME: Marie Handwerker
14. NAME OF HUSBAND OR WIFE: Ferdinand Ruppel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Mr. Theodore Ruppel
ADDRESS: 3241 Bates St

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic myocarditis — 2 yrs.

DUE TO (c) Arteriosclerosis — 3 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Possible Ca. of G.I. tract ?

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 42214
20. AUTOPSY? YES ☐ NO ☑

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) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1949, *to* 8/9, 1951, *that I last saw the deceased alive on* 8/2, 1951, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: R A Heslie MD (Degree or title)
23b. ADDRESS: Kirkwood Mo
23c. DATE SIGNED: 8/9/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-11-1951
24c. NAME OF CEMETERY OR CREMATORY: St Trinity Lutheran
24d. LOCATION (City, town, or county) (State): St Louis Co. Mo.

DATE REC'D BY LOCAL REG.: 8-10-51
REGISTRAR'S SIGNATURE: Herbert R Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE: Beiderwieden F.H. Inc
ADDRESS: 1936 St Louis Av

(Licensed Embalmer. See Statement on Reverse Side)

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

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 _____

_____, working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed Max L. Wagel

Licensed Embalmer No. 4170

P. O. Address 1936 St Louis Av

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.