

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14569

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 884

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>MARYLAND HEIGHTS</u>	c. LENGTH OF STAY (in this place) <u>2 months</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>MARYLAND HEIGHTS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bernice & Orchard Avenue</u>		d. STREET ADDRESS (If rural, give location) <u>Bernice & Orchard Avenue</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>RUTH</u>	b. (Middle) <u>W.</u>	c. (Last) <u>THOMAS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>3/19/54</u>
---	-----------------------	-------------------------	---

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/3/1926</u>	9. AGE (In years last birthday) <u>28</u>	IF OVER 1 YEAR Months Days Hours Min.
-----------------	---------------------------	--	--------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>McHus, Ark.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	--	--

13a. FATHER'S NAME <u>A.M. Plaster</u>	13b. MOTHER'S MAIDEN NAME <u>JEFFIE HACKNEY</u>	14. NAME OF HUSBAND OR WIFE <u>ROBERT THOMAS</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 NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>ROY PLASTER, MOHUE, ARK.</u>	ADDRESS
---	--	--	---------

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, asphyxia, 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) <u>from hemorrhage of the heart and internal organs, from wounds inflicted</u>		
	ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		
DUE TO (b) <u>with a knife in the hands of Robert Thomas, during a scuffle in their home</u>		DUE TO (c) <u>the night of March 19, 1954. The</u>	
II. OTHER SIGNIFICANT CONDITIONS <u>body was recovered from a shallow grave in the backyard on the premises on</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4/1/54 where she had been buried by Robt. Thomas.</u>	20. AUTOPSY? <u>YES</u> <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Homicide</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Maryland Heights St. Louis Mo.</u>
---	---	--

21d. TIME OF INJURY <u>3/19/54 11 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>Stabbed with butcher knife during scuffle with husband.</u>
---	---	--

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Amold J. Willmann</u>	(Degree or title) <u>Coroner</u>	23b. ADDRESS <u>Clayton, Mo.</u>	23c. DATE SIGNED <u>4/15/54</u>
--	-------------------------------------	-------------------------------------	------------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) <u>REMOVAL</u>	24b. DATE <u>4/3/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>EDGNER CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>INDEP. CO. ARK.</u>
--	----------------------------	--	---

DATE REC'D BY LOCAL REG. <u>4-14-54</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Batesville Funeral Home</u>	ADDRESS <u>Batesville, Arkansas</u>
--	---	--	--

(Licensed Embalmer's Statement on Reverse Side)

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

APR

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 *John M. Lawrie*

Licensed Embalmer No. *4620*

P. O. Address *Batesville, Pa.*

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.