

FILED OCT 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32779

BIRTH NO. _____		REG. DIST. NO. 333		PRIMARY REG. DIST. NO. 3074		Registrar's No. 148	
1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived, if institution: rank, grade, before admission) a. STATE Missouri b. COUNTY New Madrid			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sikeston		c. LENGTH OF STAY (in this place) 2 Days		c. CITY OR TOWN Caruthersville		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Delta Community Hospital				e. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) Wallace			b. (Middle) Chris			c. (Last) Ruffner	
4. DATE OF DEATH (Month) (Day) (Year) 10 6 1954		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 9-20-1917		9. AGE (In years last birthday) 37		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) Insurance Adjustor		10b. KIND OF BUSINESS OR INDUSTRY Farm Bureau Ins.		11. BIRTHPLACE (City and State or Foreign Country) Bay, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John H. Ruffner		13b. MOTHER'S MAIDEN NAME Ida Koch		14. NAME OF HUSBAND OR WIFE Leora Buschmann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Leora Ruffner, Caruthersville, Mo.			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Contusion of chest. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Basilar Skull Fracture, Fracture femur, R.				INTERVAL BETWEEN ONSET AND DEATH 2 days. 2 days.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway - auto		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 012 New Madrid, Mo.			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 9 54 9:20		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto accident.			
22. I hereby certify that I attended the deceased from 10-4 , 1954, to 10-6 , 1954, that I last saw the deceased alive on 10-6 , 1954, and that death occurred at 10:00 AM , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Wilson J. Rogers, M.D.				23b. ADDRESS Sikeston, Missouri		23c. DATE SIGNED 10-6-1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 10-6-54		24c. NAME OF CEMETERY OR CREMATORY BAY		24d. LOCATION (City, town, or county) (State) BAY MO	
DATE REC'D BY LOCAL REG. 10-7-54		REGISTRAR'S SIGNATURE Mrs. Clara Hunter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home - Sikeston Mo			

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

10020

10189

DATE RECEIVED OCT 11 1954
SCOTT CO. HEALTH DEPT.
CO. FILE No. 1054 211

OCT 26 1954

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.....
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Litaston

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.