

FILED MAY 13 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12154

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 498

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u> <u>0117</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo.Meth. Hosp.</u> Length of stay in lb <u>49 years</u>		d. STREET ADDRESS (If outside, give location) <u>1220 N. 3rd St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>OPAL</u> Last <u>BLOOMER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1957</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 19, 1867</u>
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (City and state or country) <u>New Point, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John P. Ruhl</u>	
14. MOTHER'S MAIDEN NAME <u>Isabel Cable</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-----</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Ruby Wagner, 1220 N. 3rd, St. Joseph, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, acute</u> DUE TO (b) <u>Arteriosclerotic Kidney Disease</u> DUE TO (c) <u>Arteriosclerosis general</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>446X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>50 hours</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Hour <u>10:30 p.</u> Month, Day, Year <u>April 28, 1957</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <u>St. Joseph Mo.</u>		20g. COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>April 28, 1957</u> to <u>May 1, 1957</u> and last saw her <u>10:30 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>St. Joseph Mo.</u>	
22c. DATE SIGNED <u>5-3-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	
23b. DATE <u>5/4/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Joseph, Mo.</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Wheaton Bowman - St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 8, 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Evelyn M. Allison</u>			

Dr. Leman

MAY 29 1951

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 *James H. Hawken*

Licensed Embalmer No. 453

P. O. Address 319 So 10th St

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.