

Health, Welfare, Public Service
 300
 1-56
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

26721
 STATE FILE NUMBER
 6224

FILED JUL 16 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6224

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Ferguson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital				Length of stay in lb 5 days		d. STREET ADDRESS (If outside, give location) 114 Reasor Dr.	
3. NAME OF DECEASED (Type or print) Ruby D. Wolf				4. DATE OF DEATH July 4, 1957.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1892	
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Canton, Missouri	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Ward				14. MOTHER'S MAIDEN NAME Elizabeth Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 494-28-5099		17. INFORMANT Sam H. Wolf	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i> <i>Unknown</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				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 Month, Day, Year a. m. p. m.			
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 COUNTY STATE		20g. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>11/15/56</i> , to <i>7/4/57</i> and last saw her ^{her} him alive on <i>7/4/57</i> . Death occurred at <i>1:50 p.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Jack T. Steele, M.D.</i>				22b. ADDRESS <i>40 N. FLORISSA AVE FERGUSON 21, MO.</i>		22c. DATE SIGNED <i>7/5/57</i>	
23a. BURIAL, CREMATION, REBURY OR REMOVAL <i>Removal</i>		23b. DATE <i>7-6-57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Grove Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Canton, Missouri</i>	
24. FUNERAL DIRECTOR <i>White Chapel, Ferguson, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>JUL 5 57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Elessai Bourice

Licensed Embalmer No. 340

P. O. Address Johning

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.