

FILED APR 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013351

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 425

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> admission <b>0117</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Arnold Nursing Home</b>		Length of stay in 1b <b>70 years</b>	d. STREET ADDRESS (If outside, give location) <b>701 S. 11th</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ANDREW RUOFF</b>			4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1958</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1868</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Swift &amp; Co.</b>	11. BIRTHPLACE (City and state or country) <b>Germany</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Ruoff</b>		13b. MOTHER'S MAIDEN NAME <b>Christine Schaber</b>		14. NAME OF HUSBAND OR WIFE <b>Katherine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>496-07-6088</b>		17. INFORMANT Address <b>Mr. John Ruoff, 2818 Duncan, St. Joseph, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure -</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Several Weeks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Old Asthma + Pulmonary Emphysema</b>					<b>Yrs</b>
DUE TO (c) <b>Coronary Artery Disease &amp; Hypertension</b>					<b>Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostatic Hypertrophy - (Severe) - Retention 4201</b>					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	
21. I attended the deceased from <b>4-24-57</b> to <b>4-19-58</b> and last saw <b>him</b> alive on <b>4-15-58</b> Death occurred at <b>10:45p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>0</b>			22b. ADDRESS <b>St. Joseph, Mo.</b>		22c. DATE SIGNED <b>4/21/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>4/22/1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
24. FUNERAL DIRECTOR <b>Heaton Bowman</b> ADDRESS <b>St. Joseph, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>April 22, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Wm. Clark Goodell</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 30 1958

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 *William Spalding* .....

Licensed Embalmer No. *4530* .....

P. O. Address *355 10th Ave* .....

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.