

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000389

FILED VS. JAN 11 1960

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STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>37 years</i>		c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Joseph Nursing Home</i> <i>3225 So. 11th St.</i>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>5900 S. 22nd St. Route 5</i>		
3. NAME OF DECEASED (Type or print) First <i>Clara</i> Middle <i>Leone</i> Last <i>Ruse</i>				4. DATE OF DEATH Month <i>January</i> Day <i>4</i> Year <i>1960</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 13, 1896</i>		
9. AGE (last birthday) <i>63</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (City and state or country) <i>Sabetha, Kansas</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Elliott Marshall</i>			13b. MOTHER'S MAIDEN NAME <i>Gertrude Parker</i>			14. NAME OF HUSBAND OR WIFE <i>Walter J. Ruse</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Walter J. Ruse Route 5, St. Joseph, Mo.</i>			
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>Cerebral arteriosclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i>	
DUE TO (b) <i>arteriosclerosis</i>							<i>6 yrs</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) <i>Diabetes</i>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year						
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 <i>1949 2:00 P</i> to <i>1-4-60</i> and last saw her alive on <i>1-4-60</i> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deputy or title) <i>Clarence C. Symons M.D.</i>				22b. ADDRESS <i>St. Joseph Mo</i>		22c. DATE SIGNED <i>1-6-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Jan 7, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>			
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>			ADDRESS		25. DATE RECD. BY LOCAL REG. <i>Jan 6, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Wm. Clark Goodell</i>	

DOCUMENT

BY AFFIDAVIT OF C.C. DuMont, M.D. MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Allin E Bagan

Licensed Embalmer No. 4795

P. O. Address St. Joseph

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.