

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031995

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 979

STATE FILE NUMBER

AMENDED

FILED OCT 2 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb most of life		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hosp.		d. STREET ADDRESS (If outside, give location) 3427 Mitchell Ave.	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First STELLA Middle R. Last RUOFF			4. DATE OF DEATH Month September Day 26 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/1/1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Real Estate Co.	11. BIRTHPLACE (City and state or country) Nebr.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Alfie Ash		13b. MOTHER'S MAIDEN NAME Mattie G. Reeder		14. NAME OF HUSBAND OR WIFE Jacob Andy Ruoff	
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. 	17. INFORMANT Address Jacob A. Ruoff, 3427 Mitchell, St. Joseph, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Ventricular fibrillation		instantaneous
DUE TO (b) arteriosclerotic heart disease		
DUE TO (c) old myocardial infarction		years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Ventricular Tachycardia, 4 days		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 checked="" 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 1958 , to 9/26/61 and last saw <u>her</u> alive on 9/26/61 Death occurred at 2:15 p. m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Donald Stallard, M.D. (Degree or title)	22b. ADDRESS 902 Edmond St
22c. DATE SIGNED 9/27/61 (State)	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept 29, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo.
24. FUNERAL DIRECTOR Hector Bowman ADDRESS St Joseph, Mo	25. DATE RECD. BY LOCAL REG. Sept. 29, 1961	26. REGISTRAR'S SIGNATURE Wm. Clark Goodell	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF
 DOCUMENT
 MEDICAL CERTIFICATION
 Stallard, M.D.

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 Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 So 10th St, Allentown, Pa

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.