

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

21313

1. PLACE OF DEATH

County.....**Jackson**
Township.....**Kaw**
City.....**Kansas City**

Registration District No.....
Primary Registration District No.....
(No.) **4600 Summitt**

File No.....
Registered No. **20355**
St. Ward)

2. FULL NAME.....**Mary Rust**

(a) Residence. No. **4600 Summitt** St. **7** Ward.

(Usual place of abode)
Length of residence in city or town where death occurred **4** yrs. mos. ds. How long in U.S., if of foreign birth? **59** yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF **Fred Rust**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 8, 1843**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
83 7 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **at home**
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

PARENTS
10. NAME OF FATHER **John Cedis**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**
12. MAIDEN NAME OF MOTHER **Mrs. Von Geschan**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT **Mrs. H. M. Franklin**
(Address) **4600 Summitt**

15. FILED **7-2 27 M M Crowe**
asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 1 1927**

17. I HEREBY CERTIFY that I attended deceased from 19....., to 19....., and that I last saw him..... alive on..... 19....., and that death occurred on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Rectum
460
45 (duration)..... yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY..... **no**

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) **Chas. Wilson**, M. D.

7-1 1927 (Address) **Deputy Coroner**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Springfield Mo.

7/2/27 19

20. UNDERTAKER

ADDRESS

Richardson Horn **City**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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