

24926

S. No. 2
M-9-4-41
5-17-39
PI X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUL 24 1943
Registration District No. _____

Primary Registration District No. 2000

Registrar's No. 536

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH: GREENE

(a) County: _____

(b) City or town: Springfield, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: One Day
(Specify whether years, months or days)

In this community: Two Years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No.: 607 West Chase
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: _____

3. (a) PRINT FULL NAME: ROY E. BRUST BRUST

3. (b) If veteran, name war: Blank

3. (c) Social Security No.: Blank

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day Fourth
year 1943 hour TWO minute 40A.M.

21. I hereby certify that I attended the deceased from July 1, 1943
to July 3, 1943, 19____;
that I last saw him alive on July 3, 1943, 19____;
and that death occurred on the date and hour stated above.

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Florence Brust

6. (c) Age of husband or wife if alive: 46 years

7. Birth date of deceased: February 15, 1889
(Month) (Day) (Year)

Immediate cause of death: Myocardial insufficiency

Duration: _____ years

8. AGE:	Years	Months	Days	If less than one day
	<u>54</u>	<u>4</u>	<u>20</u>	_____ hr. _____ min.

Due to: arteriosclerosis

Due to: _____

9. Birthplace: Unknown Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation: Laborer

Other conditions: prostatic hypertrophy
(Include pregnancy within 3 months of death)

11. Industry or business: _____

12. Name: William H. BRUST Brust

13. Birthplace: Unable to obtain unknown
(City, town, or county) (State or foreign country)

14. Maiden name: Miss Alice Davis

15. Birthplace: Unknown Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings:
Of operations: _____

Of autopsy: _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: Mrs Florence Davis Brust

(b) Address: 607 West Chase

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/7/43
(Month) (Day) (Year)

(c) Place: burial or cremation: Greenlawn Cemetery

18. (a) Signature of funeral director: Fred C. Thieme

(b) Address: 1100 Boonville, St. City

19. (a) 7-7-43 (Date received local registrar) (b) S. W. Handley (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): _____

(b) Date of occurrence: _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury: _____

23. Signature: [Signature] (If D. or other) _____

Address: Springfield, Mo. Date signed: 7-7-43

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed..... **Fred C. Thieme**.....

Licensed Embalmer No..... **2899**.....

P. O. Address..... **Springfield, Missouri**.....

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 this body is not embalmed, fact should be so stated above.