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DM—8-43
v. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 8 1944

Registration District No. 18

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 23387

Registrar's No. 6570

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 6414 Cates
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank M. Rust

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Katie Rust

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

7. Birth date of deceased August (Month) 14 (Day) 1860 (Year)

8. AGE: Years 83 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Norfolk (City, town, or county) Ohio (State or foreign country)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Benjamin Rust
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Phoebe Armstrong
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Betty Roberts

(b) Address 6414 Cates

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-44 (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 26 1944 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 25 year 1944 hour 7:30 minute A. M.

21. I hereby certify that I attended the deceased from July 21, 1944 to July 25, 1944 that I last saw him alive on July 24, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Bronchopneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Herman M. Meyer (M. D. or other) MD

Address 508 N Grand Date signed 7/26/44

(Licensed Embalmer's Statement on Reverse Side)

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address.....

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.