

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

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED SEP 26 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

30295

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

3717

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 mos. 5 days
 (Specify whether
 In this community 40 yrs.
 years, months or days)

3. (a) PRINT FULL NAME Herbert Rust

3. (b) If veteran, name war ✓ 3. (c) Social Security No. 515-09-6785

4. Sex 0 male 5. Color or race White 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife Mabel Rust 6. (c) Age of husband or wife if alive dec years
 7. Birth date of deceased July - 29 - 1873
 (Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 16 If less than one day hr. min.

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

10. Usual occupation Butcher

11. Industry or business

12. Name Unknown
 13. Birthplace Unknown (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Matherine Reed

(b) Address 1115 Forest

17. (a) Burial (b) Date thereof Sept. 16-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doshier

(b) Address 1415 E 15

19. (a) 9-14-44 (b) D. E. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1115 Forest
 (If rural, give location)
 (e) Citizen of foreign country? England (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13
 year 1944 hour 10 minute 55 A.M.

21. I hereby certify that I attended the deceased from June 8, 1944, to Sept. 13, 1944;
 that I last saw him alive on Sept. 13, 1944;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Carcinoma of rectum Duration

Due to 46

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature A. E. Warner (M. D. or other) MD
 Address Med. Dir. Gen'l Hosp Date signed 9-14-44

(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..... *J P Doshier*

Licensed Embalmer No. *1166*

P. O. Address *1415 E 15*

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.