

No. 300
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28525

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 7 1948 317

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 1989

1. PLACE OF DEATH:

(a) County St. Louis Normandy

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

(c) Name of hospital or institution:
Normandy Osteopathic Hospital
(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 _____

(c) City or town St. Louis County
(If outside city or town limits, write "RURAL")

(d) Street No. 3524 Maywood, Normandy, Mo.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME Stella Rustige

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife George H. Rustige

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased Sept. 7th, 1909
(Month) (Day) (Year)

8. AGE: Years 38 Months II Days 6 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER { 12. Name Stanley Panus

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 George H. Rustige

(b) Address 3524 Maywood, Normandy, Mo.

17. (a) Burial (b) Date thereof 8/16/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir.

(b) Address 2849 North Euclid Ave

19. (a) 8-14-48 (b) Carl R. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 13 year 1948 hour 50 minute 20 p.m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration _____
Wanted chronic
Chronic Anemia
Due to Possible Cause of
Palpitations + Pt. Pulm.
Due to _____
Other conditions 55x
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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 Dr. Carl Salinas DO (M. D. or other) _____
Address 7320 Florence Rd. Date signed 8/13/48

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

Lo 7999 As Adams

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 *Robert J. Breakman*

Licensed Embalmer No. 3553

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.