

No. 300  
0.48

FILED AUG 25 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003 State File No. 28631  
7333

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) TOWN ST. LOUIS 2179	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4145 A DETONTY ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSPITAL			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) BONITA	b. (Middle) MARIE	c. (Last) RUSTMUELLER	AUG. 15, 1951		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH DEC. 1, 1944	9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME CHARENCE RUSTMUELLER	13b. MOTHER'S MAIDEN NAME JOSEPHINE BREIG.	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME CHARENCE RUSTMUELLER ADDRESS 4145 A DETONTY ST.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE LYMPHATIC LEUKEMIA		II. OTHER SIGNIFICANT CONDITIONS		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 20 Hr 0
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22. I hereby certify that I attended the deceased from AUG. 7, 1951, to AUG. 15, 1951, that I last saw the deceased alive on AUG. 15, 1951, and that death occurred at 3:20 P. m., from the causes and on the date stated above.

23a. SIGNATURE Robert A. Hall, M.D.	(Degree or title) U	23b. ADDRESS 3902 LAFAYETTE ST. LOUIS, Mo	23c. DATE SIGNED AUG. 16, 1951
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE AUG 18, 1951	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS, Mo

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 17 1951	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
	Wm J Robert & Co. 1905 So. GRAND Blvd.

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

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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-----

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Ronald O Yakube

Licensed Embalmer No. 3917

P. O. Address St Louis Mo

**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.