

FILED JUN 24 1954

STANDARD CERTIFICATE OF DEATH

21180

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5368**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY 8120	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Belleville Ill	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		e. STREET ADDRESS (If rural, give location) 27 S 10th St Belleville	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Jane c. (Last) Rust		4. DATE OF DEATH (Month) (Day) (Year) 6 14 - 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Baby	8. DATE OF BIRTH Feb 24 1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Peter A. Rust	13b. MOTHER'S MAIDEN NAME Jane Joe Carabel	14. NAME OF HUSBAND OR WIFE none
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Peter A. Rust	18. ADDRESS 27 S 10th Belleville Ill
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 mo 20 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Pykic disease of lungs		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS 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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 759.0
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22. I hereby certify that I attended the deceased from **6-2**, 19**54**, to **6-14**, 19**54**, that I last saw the deceased alive on **6-13**, 19**54**, and that death occurred at **4:45 AM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wayne A. Rupe MD	23b. ADDRESS 7736 Maryland Clayton 5	23c. DATE SIGNED 6-14-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-14-54	24c. NAME OF CEMETERY OR CREMATORY MT Carmel	24d. LOCATION (City, town, or county) (State) Belleville Ill
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DATE REC'D BY LOCAL REG. JUN 15 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Pete Gaedner	ADDRESS Belleville Ill
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *J. Allen Davis*.....
Licensed Embalmer No. *40*.....
P. O. Address *117*.....

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**