

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026910
STATE FILE NUMBER
6981

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED JUL 21 1958

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u>		c. CITY OR TOWN <u>Beckemeyer</u> <u>8120</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John' Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Maddux Street</u>	
Length of stay in lb <u>9 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE G. DUST</u>			4. DATE OF DEATH Month Day Year <u>JULY 14 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 2, 1889</u>
9. AGE (In years last birthday) <u>69</u>	FUNDER 1 YEAR Months Day <u>4 12</u>	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>Retired Farmer - Self Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Bartelso, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Gerhardt Dust</u>	
13b. MOTHER'S MAIDEN NAME <u>Willemine Determann</u>		14. NAME OF HUSBAND OR WIFE <u>Elizabeth Dust</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Elizabeth Dust - Beckemeyer, Ill.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC PULMONARY INSUFFICIENCY</u> DUE TO (b) <u>PULMONARY FIBROSIS</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PULMONARY TUBERCULOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY .Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>7-5-58</u> to <u>7-14-58</u> and last saw her/him alive on <u>7-14-58</u> Death occurred at <u>6:30</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John H. Winter M.D.</u>		22b. ADDRESS <u>307 S. Euclid</u>	
22c. DATE SIGNED <u>7-14-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>7-17-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Beckemeyer, Illinois</u>		24. FUNERAL DIRECTOR ADDRESS <u>E. St. Louis, Ill.</u>	
25. DATE RECD. BY LOCAL REG. <u>JUL 14 '58</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u> <u>MSB</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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

Licensed Embalmer No. 7541

P. O. Address E. St. Louis

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.