

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 6 3 2

FILED VS. DEC 29 1959

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD MO		c. CITY OR TOWN MARSHFIELD MO	
Length of stay in 1b 12 YRS		Inside Limits Yes ☒ No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 608 S PINE	
Yes ☒ No ☐		Reside on Farm Yes ☐ No ☒	
3. NAME OF DECEASED (Type or print) First Middle Last LEM W RUST		4. DATE OF DEATH Month Day Year DEC 16 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 8-13-1879
9. AGE (last birthday) 89		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME NELSON RUST		13b. MOTHER'S MAIDEN NAME NANCY WHITE	
14. NAME OF ~~husband~~ OR WIFE LILLY MAY		Address	
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.	
17. INFORMANT LILLY MAY RUST		Address MARSHFIELD MO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure - Arterio-sclerosis Heart Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostatic Neoplasm - Genit Metastases		PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	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 1950 to Dec. 16 1959 and last saw him alive on Dec. 15 1959		Death occurred at 410 Pm on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) C.P. Macdonald, M.D.		22b. ADDRESS Marshfield, Mo.	
22c. DATE SIGNED 12/17/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 12-19-1959	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	
23d. LOCATION (City, town, or county) MARSHFIELD MO.			
24. FUNERAL DIRECTOR BARBER-EDWARDS		25. DATE RECD. BY LOCAL REG. 12-21-59	
ADDRESS MARSHFIELD MO		26. REGISTRAR'S SIGNATURE J. Francis	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

DEC 29 1959

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

R. W. Bar

Licensed Embalmer No. 38

P. O. Address *W. H. Evans*

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.