

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

4502 **60-035002**
STATE FILE NUMBER

FILED VS. SEP. 20 1960 149

Primary Registration District No. **1002** Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 2 1/2 years		c. CITY OR TOWN Kansas City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4439 Roanoke Pwky		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Edmund Last Rusk				4. DATE OF DEATH Month Sept. Day 1 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 12-1-1895	9. AGE (last birthday) 64	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) Branch Manager			10b. KIND OF BUSINESS OR INDUSTRY Amer. Mach. & Four.		11. BIRTHPLACE (City and state or country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles Rusk			13b. MOTHER'S MAIDEN NAME Margaret Lyons			14. NAME OF HUSBAND OR WIFE Gertrude E. Rusk		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) W. W. I.			16. SOCIAL SECURITY NO. 352-10-8753		17. INFORMANT Address Mrs Gertrude E. Rusk 4339 Roanoke			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 8 hours.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pulmonary Hypertension (post-pneumococcal)						72 hrs.		
DUE TO (c) Chronic Bronchitis.						5 years.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Lung (squamous cell) Carotid Sclerosis.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 8 Month, Day, Year 8/29/60. 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 6-27-59 to 9-1-60 and last saw her/him alive on 9-1-60 Death occurred at 7:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) P. L. Byers M.D.				22b. ADDRESS 4635 Wyandotte, K.C. 12, Mo		22c. DATE SIGNED 9/1/60.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Sept. 1, 1960	23c. NAME OF CEMETERY OR CREMATORY All Saints		23d. LOCATION (City, town, or county) (State) Des Plaines, Ill.			
24. FUNERAL DIRECTOR ADDRESS Thomas E. Quirk 701 East 63rd St.				25. DATE RECD. BY LOCAL REG. 9-2-60		26. REGISTRAR'S SIGNATURE H. L. Sawyer		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF P. L. Byers

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 37

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.