

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009321

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

1831

FILED FEB 28 1963

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                      |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)                                                                       |                                                                                                                                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>ST. LOUIS, MISSOURI</b>                                                                                                                                     |                                                                                                           | c. CITY OR TOWN <b>Ladue</b>                                                                                                                                |                                                                                                                                                                                 |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>                                                                                                                               |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><b>29 Oakleigh Lane</b>                                                                                    |                                                                                                                                                                                 |
| 3. NAME OF DECEASED<br>(Type or print) <b>Dr. AUSTIN J. RUST Jr</b>                                                                                                                                                                 |                                                                                                           | 4. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1963</b>                                                                                    |                                                                                                                                                                                 |
| 5. SEX<br><b>male</b>                                                                                                                                                                                                               | 6. COLOR OR RACE<br><b>white</b>                                                                          | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/8/1913</b>                                                                                                                                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>dentist</b>                                                                                                                       |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>medicine</b>                                                                                                        |                                                                                                                                                                                 |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>                                                                                                                                                                 |                                                                                                           | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                                                                                                |                                                                                                                                                                                 |
| 13a. FATHER'S NAME<br><b>Austin J. Rust</b>                                                                                                                                                                                         |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><b>Corrine Schaefer</b>                                                                                                        |                                                                                                                                                                                 |
| 14. NAME OF HUSBAND OR WIFE<br><b>Jacqueline Rust</b>                                                                                                                                                                               |                                                                                                           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>yes Korean</b>                             |                                                                                                                                                                                 |
| 16. SOCIAL SECURITY NO.<br><b>yes</b>                                                                                                                                                                                               |                                                                                                           | 17. INFORMANT<br><b>Jacqueline Wise Rust</b>                                                                                                                |                                                                                                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CIRRHOSIS OF LIVER, LAENNEC'S</b>                                                                |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mons.</b>                                                                                                                              |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>581.1</b>                                                                                           |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                   |                                                                                                           |                                                                                                                                                             | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____                                                                                                                                                         | 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<br>COUNTY _____ STATE _____                                                                                                    |                                                                                                                                                                                 |
| 21. I attended the deceased from <b>1/15/63</b> to <b>2/18/63</b> and last saw her alive on <b>2/18/63</b><br>Death occurred at <b>6:10 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| 22a. SIGNATURE<br>(Degree or title)<br><b>C.D. Vermillion M.D.</b>                                                                                                                                                                  |                                                                                                           | 22b. ADDRESS<br><b>BARNES HOSPITAL</b>                                                                                                                      |                                                                                                                                                                                 |
| 22c. DATE SIGNED<br><b>2/18/63</b>                                                                                                                                                                                                  |                                                                                                           | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>                                                                                               |                                                                                                                                                                                 |
| 23b. DATE<br><b>2/20/63</b>                                                                                                                                                                                                         |                                                                                                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Grove Crematory</b>                                                                                            |                                                                                                                                                                                 |
| 23d. LOCATION (City, town, or county)<br><b>St. Louis County</b>                                                                                                                                                                    |                                                                                                           | 23e. STATE<br><b>Mo.</b>                                                                                                                                    |                                                                                                                                                                                 |
| 24. FUNERAL DIRECTOR<br><b>Lupton Chapel, Inc 7233 Delmar Blvd</b>                                                                                                                                                                  |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><b>FEB 19 1963</b>                                                                                                          |                                                                                                                                                                                 |
| 26. REGISTRAR'S SIGNATURE<br><b>Head Smith M.D.</b>                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**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 Arnold H. Schoene

Licensed Embalmer No. 3864

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

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