DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35764

NOV 20 1940

Registration District No. 308

Primary Registration District No. 5685

Registrar's No. 136

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution —
(Specify whether years, months or days)

In this community 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Rich Hill Township
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ——— years.

3. (a) PRINT FULL NAME Charles A Rust

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha E Rust

6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June (Month) 12 (Day) 1857 (Year)

8. AGE: Years 83 Months 4 Days 2 If less than one day ——— hr. ——— min.

9. Birthplace Randolph (City, town, or county) Ill (State or foreign country)

10. Usual occupation Farmer

11. Industry or business —

MOTHER FATHER

12. Name James W. Rust

13. Birthplace Nashville (City, town, or county) Tenn (State or foreign country)

14. Maiden name Susan Hickerson

15. Birthplace — (City, town, or county) Tenn (State or foreign country)

16. (a) Informant's own signature Otho C Van Winkle

(b) Address Chillicothe, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation James Cem.

18. (a) Signature of funeral director James D. Gordon

(b) Address Chillicothe Mo

19. (a) Oct 17 1940 (Date received local registrar) (b) H W Mace M.D (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14 year 1940 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct, 1939, to Oct 11, 1940, that I last saw him alive on 11th Oct, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Myocarditis — *Duration*

Due to —

Due to —

Other conditions (Include pregnancy within 3 months of death) Epithelioma of face (Ulcerated).

Major findings:
Of operations —

Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury —

23. Signature Donald M. Donald M.D. (Physician)

Address Chillicothe Mo Date signed 11/19/40.

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 1 X19511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

WRITE PLAINLY—USE 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.....

Donald F. Gordon, Registered Apprentice No. 223,

working under my personal supervision.

Signed James D Gordon

Licensed Embalmer No. 1870

P. O. Address Chillicothe 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 this body is not embalmed, above space should be left blank.

S. No. 2B
M—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 35-764

Registration District No. 508 Primary Registration District No. 5685 Registrar's No.

1. PLACE OF DEATH,
(a) County Livingston
(b) City or town Rural Twp. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Chas. A. Rust.
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 2 If less than one day hrs. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 14
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma	
Due to	
Due to	
Other conditions. Epithelioma	

(Include pregnancy within 3 months of death)

Major findings: Face. (Right side of
Of operations. nose encroaching top
Of autopsy gumed Canthus & eye. This
has recently been treated by
radiation and was healed.

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Donald M. Dowell (M. D. or other)
Address Bucklin Mo Date signed 12-8-40