WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1817

1 PLACE OF DEATH

County Jasper

Township or Village or City Carterville (NO. 312 S. Pearl St.; Ward)

Registration District No. 407 File No.

Primary Registration District No. 4241 Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James C. Rusk

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May (Month) 18 (Day) 874 (Year)

7 AGE 44 yrs. 8 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Engenier 23A

(b) General nature of industry business or establishment in which employed (or employer) Stationary 1K 13M

9 BIRTHPLACE (City or town, State or foreign country) Jasper Co. Mo.

PARENTS

10 NAME OF FATHER W. M. Rusk

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Kem.

12 MAIDEN NAME OF MOTHER Elysbeth Stevenson

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Glen W. Rusk

(Address) Carterville Mo.

15 Filed 2/1, 1919 J. B. Barry Registrar

MEDICAL CERTIFICATE OF DEATH

3

16 DATE OF DEATH Jan. (Month) 30 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 30, 1919, to Jan 30, 1919, that I last saw him alive on Jan 30, 1919, and that death occurred, on the date stated above, at 10 30 P.m.

The CAUSE OF DEATH* was as follows:

Terminal cause - Bronchial Pneum lasting 5 days - Epidemic Influenza in O re lighting a tubercular affection

(Duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) R. M. Stormont M. D.

Feb 1, 1919 (Address) Carterville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Carterville Cem DATE OF BURIAL Feb 1st, 1919

20 UNDERTAKER Webb City Und Co ADDRESS Webb City Mo

MISSOURI STATE BOARD OF HEAL

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

(If death occurre hospital or instit give its NAME i of street and num

2 FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in terms of the Nomenclature of Diseases. OCCUPATION ... important.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.... (
(Month) (Day)

17 I HEREBY CERTIFY, that I attended deceased

....., 191....., to ....., 191

that I last saw h..... alive on ....., 191

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. .....

(Signed) ..... M

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes (1) Means of Injury; and (2) whether Accidental, Suicidal or Homic

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transi or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

CORD—DO NOT

20 UNDERTAKER | **ADDRESS**