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

Do not use this space.

18140

1. PLACE OF DEATH

County ..... Registration District No. 7 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 5298

City Sheets (No. City Hospital ..... St. ..... Ward)

2. FULL NAME Lena Rusche

(a) Residence. No. 5614 S Magnolia Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Otto Rusche

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16 1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	70	9	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife 59 131
(b) General nature of industry, business, or establishment in which employed (or employer) 936
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER John Rust.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Ormond
(Address) City Hospital

15. FILED MAY 31 1930 Max C. Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1930

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to May 29, 1930 that I last saw h... alive on May 29, 1930 and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
Chronic nephritis
Chronic Myocarditis
..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory
(Signed) Carl J. Hoh, M.D.
May 29, 1930 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New St. Paul Cem	May 31 1930
20. UNDERTAKER	**ADDRESS**
Haucke & Schmitt	3737 S. Grand

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, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Rusche