

DEC 15 1939

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

39542  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Franklin Registration District No. 297  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3016  
 (c) City Washington, Mo. (d) Street No. 211 West 5th St. St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 51 yrs. 6 mos. 14 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emma Marie Rusche  
 (a) Residence, No. 211 West 5th St., Washington, Mo. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX <b>Female</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Widowed</b>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Arthur Rusche</b>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <b>May 10th, 1888</b>				
7. AGE	YEARS <b>51</b>	MONTHS <b>6</b>	DAYS <b>14</b>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <b>Housewife</b>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <b>Home</b>			
	10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) <b>Washington</b> (STATE OR COUNTRY) <b>Missouri</b>				
FATHER	13. NAME <b>John Henry Koch</b>			
	14. BIRTHPLACE (CITY OR TOWN) <b>Not known</b> (STATE OR COUNTRY) <b>Germany</b>			
MOTHER	15. MAIDEN NAME <b>Catharine Boesemann</b>			
	16. BIRTHPLACE (CITY OR TOWN) <b>Not known</b> (STATE OR COUNTRY) <b>Germany</b>			
17. INFORMANT <b>Miss Robena Rusche</b> (ADDRESS) <b>211 W. 5th St., Washington, Mo.</b>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <b>Washington, Mo.</b> DATE <b>Nov. 27, 1939</b>				
19. FUNERAL DIRECTOR (NAME) <b>Otto &amp; Co.,</b> (ADDRESS) <b>Washington, Mo.</b>				
20. FILED <u>Nov. 25</u> 19 <u>39</u> <u>St. Mary</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR) <b>November, 24, 1939</b>	
22. I HEREBY CERTIFY, That I attended deceased from <b>November, 11, 1933</b> to <b>November, 24, 1939</b> I last saw her alive on <b>November, 23, 1939</b> . Death is said to have occurred on the date stated above, at <b>12 noon</b> . The principal cause of death and related causes of importance were as follows: <b>Carcinoma, Rt. Breast</b> <b>" left hip joint</b>	
Other contributory causes of importance: _____	
Name of operation <b>Radical amputation of breast</b> Date of onset <b>9/38</b> What test confirmed diagnosis <b>biopsy</b> Was there an autopsy? <b>No</b>	
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____ Where did injury occur? _____ (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. _____	
Manner of injury _____ Nature of injury _____	
24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____ (Signed) <b>E. C. Turner M.D.</b> M-D <b>270</b> (Address) <b>Washington Mo.</b>	

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.

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, .....

*Henry W. Otto*

or by .....

Registered Apprentice No....., working under my personal supervision.

Signed

*Henry W. Otto*

Licensed Embalmer No.

*3560*

P. O. Address

*Washington*

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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39542  
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 297  
(b) Township \_\_\_\_\_ Primary Registration District No. 3016 Registered No. \_\_\_\_\_  
(c) City Washington Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Emma Marie Rusche  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS 31 MONTHS 6 DAYS 14 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 24, 1939  
22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Carcinoma Rt. Breast  
left hip joint 50  
Carcinoma Rt. Breast.  
Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

Other contributory causes of importance:  
As far as known, the primary nat. of the malignancy was in the right breast.

13. NAME \_\_\_\_\_

Name of operation Radical Amp. Breast Date of \_\_\_\_\_  
What test confirmed diagnosis? Biopsy Was there an autopsy? no

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_ (Signed) E. C. Jessner M.D.  
(Address) Washington Mo

20. FILED Jan-12-1940 H.A. May Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
Every record or information should be carefully supplied. AGE should be stated EXACTLY. ALL PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

