

Registration District No. **78**

Primary Registration District No. **51153 E**

Registrar's No. **12**

1. PLACE OF DEATH: **Boone Missouri**
 (a) County **Boone**
 (b) City or town **ROCHPORT**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **RURAL #12**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **NO**
 In this community **Since Aug 2 1939**
 years, months or days

2. USUAL RESIDENCE OF DECEASED: **1**
 (a) State **Missouri** (b) County **Boone**
 (c) City or town **ROCHPORT**
 (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 **Eva RUDE 300**
 (b) If veteran, name war **NO**
 (c) Social Security No. **NO**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 (b) Name of husband or wife **Clyde RUDE** 6. (c) Age of husband or wife if alive **72** years
 7. Birth date of deceased **Oct 28 1866**
 (Month) (Day) (Year)

8. AGE: Years **75** Months **1** Days **21** If less than one day hr. min.

9. Birthplace **White Cloud Kansas**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **FARMER**

12. Name **Hudson Myers 9**

13. Birthplace **Don't know 5**
 (City, town, or county) (State or foreign country)

14. Maiden name **Mollie OROCK**

15. Birthplace **IRELAND**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **H. Rude**

(b) Address **Rochport Mo**

17. (a) **Rochport** (b) Date thereof **Dec 21 1939**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rochport Cem**

18. (a) Signature of funeral director **R. O. Vincent**

(b) Address **Columbia**

19. (a) **12-23-39** (b) **Mary M. Angel**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **21** 19**39** hour **5.20** minute **P.** M.

21. I hereby certify that I attended the deceased from **Aug 3-39**
Aug 3, 19**39**, to **Dec 19**, 19**39**;
 that I last saw him alive on **Sept 28**, 19**39**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of lung**

Due to _____

Due to _____

Other conditions **45**
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

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?
 While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **W. E. Russell** (M. D. or other) _____

Address **Rochport Mo** Date signed **12-20-39**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

A. Robert

Licensed Embalmer No.....

3183

P. O. Address.....

Columbia 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.