

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

12749

Do not use this space.

1. PLACE OF DEATH

(a) County Warren Registration District No. 887
 (b) Township Charrette Primary Registration District No. 6176
 (c) City or (d) Street No. 2 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 30 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William August Rusche

(a) Residence, No. 0 St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wilhelmine Rusche</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 22 1878</u>		
7. AGE	YEARS <u>61</u>	MONTHS <u>9</u>
	DAYS <u>4</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Blacksmith</u>	
	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) <u>Jan. 1940</u>	11. Total time (years) spent in this occupation <u>40 years</u>
12. BIRTHPLACE (CITY OR TOWN) <u>Glasgow Missouri</u> (STATE OR COUNTRY) <u>Missouri</u>		
FATHER	13. NAME <u>Ernst W. Rusche</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Caroline Heneke</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Femme Osage</u> (STATE OR COUNTRY) <u>Missouri</u>	
17. INFORMANT <u>Helen Rusche</u> (ADDRESS) <u>Marthasville Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Marthasville, Mo</u> <u>Mar. 29 1940</u>		
19. FUNERAL DIRECTOR (NAME) <u>Fred W. Lightenberg</u> (ADDRESS) <u>Marthasville Mo</u>		
20. FILED <u>3/29 1940</u> <u>H. C. Johnson</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-26 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1940 to Mar 26 1940.
 Last saw him alive on Mar 26 1940 Death is said to have occurred on the date stated above, at 8 P. M.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Oropharynx / Sept 1939
Carcinoma of Stomach / cardiac ind.

Date of onset

2 mo

Other contributory causes of importance:

Insanition

Name of operation none Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

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) Dubert H. Schmidt !, M. D.
 (Address) Marthasville, Mo

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.

1 X18605

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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

Fred W. Lightenberg

Licensed Embalmer No. *1321*

P. O. Address *Marionville*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12749 7

Registration District No. 884

Primary Registration District No. 6176

Registrar's No.

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

1. PLACE OF DEATH:

(a) County. Warren
(b) City or town. Charrette
(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.
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm August Rusche

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. year

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

8. AGE: Years 61 Months 9 Days 4 If less than one day, h. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

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)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month. Mar day. 26
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.

Immediate cause of death. Carcinoma of Esophagus Carcinoma of Stomach

Due to. Cardiac Endo

Due to. Don't know primary site of malignancy. Was found late.

Other condition. (Include pregnancy within 3 months of death)

Major findings: Of operation. Transition 46

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?

While at work? (Specify type of place) (e) Means of injury.

23. Signature. Herbert H Schmidt M.D.

Address. Marshville Day signed

SUPPLEMENTAL

Registration District No. 884

Primary Registration District No. 6176

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wagoner

(b) City or town Charlottesville
(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 Wm August Rusche

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Mar day 26
year 1940 hour _____ minute _____ M.

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 _____ year

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death Carlinoma of Esophagus (Primary) Cardiac End

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

8. AGE: Years 61 Months 9 Days 4 If less than one day _____ h. _____ min.

Due to Cardiac End

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

Major findings: Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name _____

13. Birthplace: (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

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)

(e) Means of injury _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof: (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

23. Signature Herbert H. Schmidt - M.D. (M. D. or other) _____

Address Northville Date signed _____

SUPPLEMENTAL

Physician

Signature _____

Underline the cause to which death should be charged statistically.

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