

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 18922

Registration District No. 508

Primary Registration District No. 5674

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Livingston
 (b) City or town Chillicothe Township
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Accident at
4 South of Chillicothe
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether
 In this community All life
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County LINN
 (c) City or town WHEELING, Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. "Rural" EVERSONVILLE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
 year 1940 hour 5:50 P.M. minute 550 P.M.

21. I hereby certify that I attended the deceased from never, 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 Brain Injury

Due to Auto accident for minutes

Due to _____

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

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy none
 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) Accident
 (b) Date of occurrence June 1, 1940
 (c) Where did injury occur? Chillicothe Livingston Mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway (Specify type of place)

While at work? no (e) Means of injury Auto Accid

23. Signature Emilie (M. D. or other) _____
 Address Chillicothe, Mo. Date signed 6/2/40

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

3. (a) PRINT FULL NAME James Alva Dust 230

3. (b) If veteran, name war ✓ 3. (c) Social Security No. NONE

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife May Dust 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Nov 7 1884
 (Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
 12. Name Henderson Dust
 13. Birthplace Virginia
 (City, town, or county) (State or foreign country)
 14. Maiden name Billy Ann Rowark
 15. Birthplace Tennessee
 (City, town, or county) (State or foreign country)

16. (a) Informant George E. Dust

(b) Address Garbado Mo P.P. #1

17. (a) Burial (b) Date thereof June 3 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parson Creek Cem.

18. (a) Signature of funeral director Smiley Funeral Home

(b) Address Wheeling Mo

19. (a) 6-2-40 (b) Emilie (Registrar's signature)
 (Date received local registrar) (Date)

210 m
95

RECEIVED

District Health Officer No. 11

District File Number 640-890

Date Filed JUN 12 1940

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 _____

Frank L. Smiley

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed

Frank L. Smiley

Licensed Embalmer No. 470

P. O. Address Wheeling, W. Va.

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.

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 18922

Registration District No. 508

Primary Registration District No. 6674

Registrar's No.

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chellethe 70
(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
years, months or days)

In this community..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME James Alva Rust

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.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

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

8. AGE: Years 25 Months 6 Days 25 If less than one day..... 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)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (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 June day 1 year 1940 hour..... minute..... M.

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: Beam Injury Duration.....

Due to auto accident

Due to collision with another motor vehicle

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

Major findings: Of operations.....

Of autopsy.....

PHYSICIAN 2/10/42

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 C. W. Grace (M. D. or other)
Address Chellethe Mo. Date signed 7/11/41

SUPPLEMENTAL

S-18922