

S. No. 2
M-8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 8 1946
STANDARD CERTIFICATE OF DEATH

State File No. **8268**
Registrar's No. _____

Registration District No. **357** Primary Registration District No. **6198**

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Rural Cass Sup
(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 30 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Texas 107
(c) City or town Rural Cass Sup
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ROBERT EDWARD RUST
3. (b) If veteran, name war _____ 3. (c) Social Security No. 498-12-8036
4. Sex m. 5. Color or race w. 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Stella 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Dec 24 1889
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 20 year 1946 11 hour 30 minute P. M.
21. I hereby certify that I attended the deceased from FEB 20, 1946 to FEB 20, 1946;
that I last saw him alive on FEB 20, 1946;
and that death occurred on the date and hour stated above.

8. AGE: Years 56 Months 1 Days 26 If less than one day _____ hr. _____ min.
9. Birthplace Cabool Mo (City, town, or county) (State or foreign country)

Immediate cause of death CEREBRAL APOPLEXY Duration _____
Due to HYPERTENSIVE CARDIORENAL VASCULAR DISEASE
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Farmer
11. Industry or business _____
MOTHER FATHER
12. Name William a. Rust
13. Birthplace Tenn (City, town, or county) (State or foreign country)
14. Maiden name Sarah Glenn
15. Birthplace Tenn (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Stella Rust
(b) Address Houston Mo.
17. (a) Burial (b) Date thereof Feb 24 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Oak Dale
18. (a) Signature of funeral director Dayford V. Elliott
(b) Address Cabool Mo
19. (a) Feb 21 (b) Gaynell Cunningham
(Date received local registrar) (Registrar's signature)

Major findings: 13/10
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) (e) Means of injury 0
23. Signature L. M. Dellman (M. D. or other) M.D.
Address HOUSTON MO Date signed 2-22

RECEIVED
District Health Officer No. 5.
District File Number 346190
Date Filed 3-7-46

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 Gaylord V. Elliott
Licensed Embalmer No. 2252
P. O. Address Cabool 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, fact should be so stated above.