

Registration District No. 862

Primary Registration District No. 6/35-

Registrar's No. 37

1. PLACE OF DEATH:

(a) County Texas(b) City or town Rural Burdine

(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 2

In this community

years, months or days

8. (a) PRINT FULL NAME William Alexander Rust

8. (b) If veteran,

name war no

8. (c) Social Security

No. none4. Sex m

5. Color or

race w

6. (a) Single, widowed, married,

divorced widow6. (b) Name of husband or wife Sarah

6. (c) Age of husband or wife if

alive 23 years7. Birth date of deceased Jan 28 1858

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

82518

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name

unknown9

13. Birthplace

unknown

(State or foreign country)

14. Maiden name

Emma Hunt

16. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

John Rust

(b) Address

Cabool Mo17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof

July 18 1940

(Month) (Day) (Year)

(c) Place: burial or cremation

Pleasant Grove

18. (a) Signature of funeral director

Gaylord V. Elliott

(b) Address

Cabool Mo19. (a) July 18

(Enter local registrar)

(b) Miss Lois Cunningham

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo(b) County Texas

(c) City or town

Rural

(If outside city or town limits, write "RURAL")

(d) Street No.

Burdine Jwp

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16
year 1940 hour 4 minute 10 P. M.21. I hereby certify that I attended the deceased from May 20 1940 to July 16 1940
that I last saw him live on July 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Debility

Due to

Due to

Other conditions

(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)

(e) Means of injury

23. Signature

J. W. Goats (M. D. or other)

Address

Cabool Mo signed

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

840846

194 B
99

STATE OF TEXAS

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 Taylor Wilcox
Licensed Embalmer No. 2252
P. O. Address Cabool

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. **29937**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **862**

Primary Registration District No. **6135**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Texas**
(b) City or town **Burdine T.P.**
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME **Wm. Alexander Ruel**

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 **wid**

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 **82** Months **5** Days **18** If less than one day _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Don't know**

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

14. Maiden name **Skuller**

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

16. (a) Informant **Johney Ruel, Son**

(b) Address **Labool 220**

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)

2. USUAL RESIDENCE OF DECEASED:

(a) State **TX** (b) County **Texas**
(c) City or town **Rural** (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.

DECEASED CERTIFICATION

20. DATE OF DEATH: Month **July** day **16** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to **July**, 19____; that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Senility and Fractured Femur**

Due to _____

Due to _____

Other conditions **1940** (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) **anxiety**

(b) Date of occurrence **April 1940**

(c) Where did injury occur? **Texas** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **home on farm**

While at work? **leading boy** (Specify type of place) (Means of injury)

23. Signature **J. Ruel** (M. D. or other)

Address **Labool TX** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

TEMPORARILY

