

OCT 30 1928

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

Do not use this space.

30941

1. PLACE OF DEATH

County Lafayette Registration District No. 460
Township _____ Primary Registration District No. 4274
City Higginsville, Mo. St. _____ Ward _____

2. FULL NAME

Chester Herman Russell

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 21st 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
11 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____
119A
1090
36

9. BIRTHPLACE (CITY OR TOWN) Higginsville, Mo.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER W. B. Russell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Jasper Co. Mo.

12. MAIDEN NAME OF MOTHER Meta Brede

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Corder, Mo.

14. INFORMANT Walter B. Russell
(Address) _____

15. FILED 9/4, 19 28 Bessie P. Porter
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 23 19 28

17. I HEREBY CERTIFY That I attended deceased from Sept 2, 19 28 to Sept 3, 19 28 that I last saw him alive on Sept 3, 19 28 and that death occurred, on the date stated above, at noon m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cholera Infantum

CONTRIBUTORY (SECONDARY) Septicemia and Meningitis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. no

19. DID AN OPERATION PRECEDE DEATH. no DATE OF _____

20. WAS THERE AN AUTOPSY. no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Physical
(Signed) Alison Davis, M. D.
, 19 (Address) Higginsville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery Corder Mo DATE OF BURIAL 9-4 1928

20. UNDERTAKER Associated Higginsville Mo ADDRESS

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.

