

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

Do not use this space.

34448

1. PLACE OF DEATH

101 County Swann
Township _____
City Winona (No. _____) St. _____ Ward _____

Registration District No. 823
Primary Registration District No. 449

File No. _____
Registered No. _____

2. FULL NAME

James Walter 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jun 13, 1888

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 3 22

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) Laborer 237
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Swann Co Mo

10. NAME OF FATHER James W. Russell

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

12. MAIDEN NAME OF MOTHER Sarah Patterson

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

14. INFORMANT Earl Russell (Address) 3702 N. Market St. Kansas City

15. FILED 10-6-1932 Mabel Beck REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 5 1932

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 140 B m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis
23A 23 (7)
93D (duration) _____ yrs. mos. da.
CONTRIBUTORY (SECONDARY) Pulmonary Tuberculosis
about (duration) 12 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Permission from Dr. J. Nyce IF NOT AT PLACE OF DEATH. _____

DID AN OPERATION PRECEDE DEATH. No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Mabel Beck, Reg., M. D.
10-6-1932 (Address) Swann 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 DATE OF BURIAL

Old Cemetery Winona Mo Oct 6 1932

20. UNDERTAKER ADDRESS

None

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

M. 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.

NOV 30 1932

