

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.

*Freeman* MAY 25 1935 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

8839

1. PLACE OF DEATH

County *Greene* Registration District No. *318* File No. *201*  
Township \_\_\_\_\_ Primary Registration District No. *2001* Registered No. \_\_\_\_\_  
City *Springfield Mo* (No. *309 W. Chase St*) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*Infant son of Ralph Russell*

(a) Residence, No. *309 W. Chase* St. \_\_\_\_\_ Ward. \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *Drs. 0 mos. 0 ds.* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Still Born*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 31 1935*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, *9* hrs. or *4* min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Springfield Mo*

FATHER 13. NAME *Ralph Russell*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Millard Mo*

MOTHER 15. MAIDEN NAME *Orlene Bussel*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Conway Mo*

17. INFORMANT (ADDRESS) *Ralph Russell 309 W. Chase St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Rose Hill* DATE *April 2 1935*

19. UNDERTAKER (ADDRESS) *Fred C. Threine Springfield Mo*

20. FILED *4-1 1935* *John W. Wells* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 31 1935*

22. I HEREBY CERTIFY, That I attended deceased from *3/31* 19*35* to *3/31* 19*35*  
I last saw him alive on *3/31-30* 19\_\_\_\_. Death is said to have occurred on the date stated above, at *10 a.* m.  
The principal cause of death and related causes of importance were as follows:

*8 1/2 mo - A*

Other contributory causes of importance:  
*Respiratory infection from birth*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) *J. H. Freeman*, M. D.  
(Address) *Springfield Mo*

