

JUL 3 0 1937

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

Do not use this space.

2

24403

1. PLACE OF DEATH

County *New Madrid* Registration District No. *274*
Township *Beauvois* Primary Registration District No. *6261*
City *Filbourn* (No. St. Ward)

File No.
Registered No.

2. FULL NAME

Sayer B. Russell
(a) Residence, No. *Suburban #1* St. Ward.

Length of residence in city or town where death occurred yrs. *16* mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-1-1937*

22. I HEREBY CERTIFY, That I attended deceased from *5-21-37*, to *6-30-37*

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

I last saw *him* alive on *5-30-37*. Death is said to have occurred on the date stated above, at *9250a*. The principal cause of death and related causes of importance were as follows:

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

Feb 1-1873

Gastritis

7. AGE

YEARS

64

MONTHS

4

DAYS

0

If LESS than 1 day, hrs. or min.

Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Farmer

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 *Life*

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Geneseo, Mo.

13. NAME

Robert Russell

Name of operation Date of

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

unknown

What test confirmed diagnosis? Was there an autopsy?

15. MAIDEN NAME

unknown

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19.....

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

unknown

Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Sayer Taylor

Manner of injury

18. BURIAL, CREMATION, OR REMOVAL

PLACE *postmortally* DATE *6-1-37*

Nature of injury

19. UNDERTAKER (ADDRESS)

W. S. Smith, Mo.

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

20. FILED

June 20, 1937 *L. E. Jones* Registrar.

(Signed)

G. Russell, M. D.
Filbourn Mo
(Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

11809-

COMPLETED AS PRESCRIBED BY LAW.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid
Township.....
City Litbourn (No.....)

Registration District No. 274
Primary Registration District No. 6261

File No. 24403
Registered No.....
St..... Ward.....

2. FULL NAME Sam B. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 4 0

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

FATHER MOTHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19.....

19. UNDERTAKER (ADDRESS)

20. FILED July 10, 1937 E. E. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-1, 1937

22. I HEREBY CERTIFY, That I attended deceased from....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Septicemia
gastric contents

Date of onset

Other contributory causes of importance:

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) G. J. Wilson, M. D.
(Address) Litbourn Mo

SUPPLEMENTARY

120B

FORMS NOT TO BE RECEIVED FOR CERTIFICATES

24403