

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

I X 11023

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.

REC'D AUG 12 1938

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

23239  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township **St Louis Mo**..... Primary Registration District No. **1008**  
(c) City..... (d) Street No. **1723a Iowa St.**..... Registered No. **5933**  
(e) Length of residence in city or town where death occurred **8** yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

**Hazel Irene Russell** **240**  
(a) Residence, No. **1723a Iowa St.** St. **23** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb 12 1923**

7. AGE YEARS **15** MONTHS **4** DAYS **18** IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Nurse Girl**  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) **6-30-38** 11. Total time (years) spent in this occupation

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

FATHER 13. NAME **William Russell**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Salem Mo.**

MOTHER 15. MAIDEN NAME **Ladie Barry**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bellview Mo.**

17. INFORMANT **William Russell**  
(ADDRESS) **1723a Iowa St**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Salem Mo** DATE **JUL 1 1938**

19. FUNERAL DIRECTOR (NAME) **Albert H Hoppe,**  
(ADDRESS) **429 N Euclid Ave**

20. FILED **JUL 1 1938** **J. F. Buddek**  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **6/30 1938**

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at **5:00 P.M.**

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

**Acute Gastro Enteritis;**  
**Cause Undetermined;**

Other contributory causes of importance: **120° F.**

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? **Yes**

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) **Joseph M. Quinn**  
(Address) **Wesley Corner**

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**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.....

*J. S. Sullivan*

Licensed Embalmer No... *1122* .....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**