

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

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.

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

35445
 Do not use this space.

NOV 8 1939

1. PLACE OF DEATH
 (a) County Bates Registration District No. 47
 (b) Township Mound Primary Registration District No. 5071
 (c) City _____ (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Russell J. Lee Masters
 (a) Residence, No. _____ St. Butler, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22 1907

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>32</u>	<u>1</u>	<u>17</u>	

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

9. Industry or business in which work was done, as saw mill, bank, etc. Inn Hotel

10. Date deceased last worked at this occupation (month and year) Oct 9, 1939 11. Total time (years) spent in this occupation 2

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

FATHER 13. NAME William Lee Master 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kokomo Indiana

MOTHER 15. MAIDEN NAME Wolly Hammell 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Russell Lee Masters (ADDRESS) Butler Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill DATE Oct 12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Culver's Butler Mo.

20. FILED Oct 31 1939 Ethel C. Stephens Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw him _____ 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: Highway Accident U.S. # 71
Fractured Left Hip
Multiple Fractures of Jaw
Fractured Skull Date of onset _____

Other contributory causes of importance: Numerous Lacerations of Head & Face
Hemorrhage

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 10/9 1939
 Where did injury occur? Adrian, Bates Co., Mo. (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. Public Highway U.S. # 71
 Manner of injury Automobile Accident
 Nature of injury Fractures

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____ (Signed) Richard H. Smith M. D.
 (Address) Cameron, Bates Co., Mo.
Rich Hill, Mo.

210 m

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, _____

~~Denton Peale~~, or by Denton Peale

Registered Apprentice No. 163, working under my personal supervision.

Signed Hattie G. Oulver

Licensed Embalmer No. 3069

P. O. Address Buster, Mo

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

35-445

Do not use this space.

1. PLACE OF DEATH

(a) County Pates Registration District No. 47
 (b) Township Mount Primary Registration District No. 2071 Registered No. 19
 (c) City..... (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Russel J Lee Masters
 (a) Residence, No..... St. (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 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.
37 1 17

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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)
 11. Total time (years) spent in this occupation

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19..

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 9 1939

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..... m.

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

Head accident, U.S. # 71
fractured left hip
multiple fract left hip
multiple fract of jaw
fract of skull

Other contributory causes of importance:
numerous laceration of head
face hemorrhage

Name of occupation.....
 What test was performed and positive? Was there an autopsy?

Was death caused by natural cause, accident, or also the following:
 (accident, suicide, or homicide)? Date of injury 10/9 1939

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 Pallid H Smith M. D.
 (Signed) Rich Hill M.D.
 (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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

