

MAY 7 1940

Registration District No. 417

Primary Registration District No. 3021

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Nett City
(c) Name of hospital or institution: 501 S DEVON.
(d) Length of stay: In hospital or institution. 2
In this community years, months or days 2 11

3. (a) PRINT FULL NAME David Russell

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Widowed 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 14 1858
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 16 If less than one day hr. min.

9. Birthplace Smith County Tenn. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retailer

11. Industry or business _____

12. Name Walter Russell

13. Birthplace Ill. (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Boston

15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Records (b) Address XXXX

17. (a) Burial (b) Date thereof May 2 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Carterville, Tenn.

18. (a) Signature of funeral director Nett City Mort Co.

(b) Address Nett City, Mo.

19. (a) APR. 30. 40 (b) J. P. O'Leary, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper
(c) City or town Nett City
(d) Street No. 501 S Devon
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1940 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 9 1940 to April 30 1940
that I last saw him alive on April 25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocardite

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 377

(Specify type of place) While at work _____ (a) Means of injury _____

23. Signature J. P. O'Leary, M.D. (M. D. or other) _____
Address Nett City, Mo. Date signed 4/30/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

40-5-31.

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.....

Licensed Embalmer No.....

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.