No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41660

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. ~~5053~~

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits write "RURAL")

(d) Street No. No. 419 Cherry
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME PETE RUSSELL

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb. 23rd 1878 (Month) (Day) (Year)

8. AGE: Years 62 Months 8 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)

10. Usual occupation Huckster

11. Industry or business

FATHER
12. Name Joseph Russell
13. Birthplace (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Mary O'Brien
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K.C. General Hospital, K.C. Mo.

17. (a) Burial Society (Burial, cremation, or removal) (b) Date thereof 12-13-40 (Month) (Day) (Year)
(c) Place: burial or cremation K.C. Gen. Hospt

18. (a) Signature of funeral director Wm. A. Lohmeyer
(b) Address K.C. Gen. Hospt

19. (a) Dec. 31, 1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9th
year 1940 hour 4 minute 45 P M.

21. I hereby certify that I attended the deceased from 11-5-40, 19__, to 11-9-40, 19__; that I last saw him alive on 11-9-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Auricular fibrillation	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Drury R. Shom (M. D. or other)
Address Med. Dir. K.C. Gen. Hospital Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 Wm A Lohmeyer

Licensed Embalmer No. 3089

P. O. Address.....

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

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