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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43821

Registration District No. 784 Primary Registration District No. 700 Registrar's No. 2408

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Koch, Missouri (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days. (Specify whether
In this community years, months or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis. (If outside city or town limits, write "RURAL")
(d) Street No. 2717 Chipewa (If rural give location)
0
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Mrs. Ruth Russell
3. (b) If veteran, name war —
3. (c) Social Security No. None
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas Russell
6. (c) Age of husband or wife if alive years
7. Birth date of deceased 10 (Month) 30 (Day) 23 (Year)

8. AGE: Years 17 Months Days 20 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife 0
11. Industry or business — 0
FATHER
12. Name Phillip Geuen 0
13. Birthplace St. Louis (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Ruth Beal
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Thomas Russell
(b) Address 2717 Chipewa St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23/40 (Month) (Day) (Year)
(c) Place: burial or cremation Park Lawn
18. (a) Signature of funeral director Thos Kutis
(b) Address 2906 Gravois Ave
19. (a) DEC 20 1940 (Date received local registrar) (b) T. R. Meyer MD Dep'y (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 20 year 1940 hour 12 minute 35 P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw her alive on December 20 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	4 mo.
Due to	
Due to	
Other conditions Intestinal tuberculosis (?) (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy Not performed

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) No
(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 R. E. Lovgren, M.D. (M. D. or other) 1
Address Robert Koch Hospital Date signed 12/20/40

(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

Thos Lutes, Registered Apprentice No.

working under my personal supervision.

Signed Thos Lutes

Licensed Embalmer No. 1629

P. O. Address 2906 Grove

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, fact should be so stated above.