

FILED MAY 6 1943

149

1002

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

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 No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community 65 yrs
years, months or days)

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. 1719 Prospect
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jesse Russell

3. (b) If veteran, name war
3. (c) Social Security No. 495-10-2153

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Div 3

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

7. Birth date of deceased 1 28 1878
(Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days 29
If less than one day hr. min.

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

10. Usual occupation Lumber handler

11. Industry or business Lumber yard

12. Name Jesse R. Russell

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

14. Maiden name Margaret M. Sallen

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

16. (a) Informant J. W. Russell

(b) Address 4111 Penn

17. (a) Burial (b) Date thereof April 29, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director J. P. Washler

(b) Address 1415 E 19

19. (a) 4-28-43 (b) M. M. Crowe
(Date received local registry) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th
year 1943 hour 1 minute 55 P. M.

21. I hereby certify that I attended the deceased from 2-16-43 19____ to 4-27-43 19____;
that I last saw him alive on 4-27-43 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Squamous cell carcinoma of left gum

Due to 450
Due to _____

Other conditions Chronic Rheumatic heart disease
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy See above

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? _____

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

23. Signature Dr. R. Thoma (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

MOTHER FATHER

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

36.

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.....

H. P. Kochler

Licensed Embalmer No..... *1166*

P. O. Address..... *1415 E 15*

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.