

S. No. 2
M-5-42
7-5-17-39
-1 X326

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14151

State File No. _____

Registrar's No. 53

Registration District No. 98

Primary Registration District No. 4164

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

1. PLACE OF DEATH:

(a) County Davies
(b) City or town Alta Mont Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Davies
(c) City or town Alta Mont
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Sarah Claressa Russell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

6. (b) Name of husband or wife Ernest Russell 6. (c) Age of husband or wife if alive 70 years (Month) (Day) (Year)

7. Birth date of deceased 1 2 1875 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 3 21 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph Brown
13. Birthplace Ohio (City, town, or county) (State or foreign country)

14. Maiden name Sarah Ann Zimmerman
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Seymour M. Etwam
(b) Address Seymour, Mo.

17. (a) (b) Date thereof 4-25-43 (Month) (Day) (Year)
(c) Place: burial or Shamberg Hotel Co. Mo.

18. (a) Signature of funeral director Mr. Kate Spoff
(b) Address Winstons Mo

19. (a) 4-26-43 (b) S. A. Johnson (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23 year 1943 hour 4 minute 2 M.

21. I hereby certify that I attended the deceased from April 17, 1943, to April 23, 1943 that I last saw her alive on April 22, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to 8301

Other conditions Chronic Cholelithiasis (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? _____ (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)
(e) Means of injury _____

23. Signature Fred Wilson (M. D. or other) _____
Address Winstons Date signed 4-23-43

Duration April 17-23 1943

several years

PHYSICIAN

Underline the cause to which death should be charged statistically.

1084

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. 1180

P. O. Address Cameron, 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, fact should be so stated above.