

No. 2
11-10-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

24659

State File No.

FILED JUL 22 1943

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 131

1. PLACE OF DEATH

(a) County Cass
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 14
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution F (Specify whether)
In this community 60 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass
(c) City or town Harrisonville
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Eliza Jane Russell

3. (b) If veteran, name war L 3. (c) Social Security No. L

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Samuel Russell 6. (c) Age of husband or wife if alive 3 years 1883
7. Birth date of deceased Oct (Month) 3 (Day) 1883 (Year)

8. AGE: Years 89 Months 9 Days 5 If less than one day hr. min.

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

10. Usual occupation house wife

11. Industry or business _____

12. Name John Jack

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

14. Maiden name Barthula (City, town, or county) (State or foreign country)

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

16. (a) Informant Joe Truesdell

(b) Address Harrisonville Mo

17. (a) Rural (Burial, cremation, or removal) (b) Date thereof July 10-1943 (Month) (Day) (Year)

(c) Place: burial or cremation Acacia Cemetery

18. (a) Signature of funeral director RUNNENBURGER'S

(b) Address HARRISONVILLE, MO

19. (a) July 10, 1943 (Date received local registrar) (b) Margaret Valle (Registrar's signature)

W. S. Scott (Signature)

Licensed Embalmer's Statement on Reverse Side

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8 1943
year _____ hour one minute thirty M.

21. I hereby certify that I attended the deceased from July 8 1943 to July 8 1943
that I last saw him alive on July 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension with cerebral hemorrhage
Due to _____

Other conditions (Include pregnancy within 3 months of death)
Due to _____

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 W. S. Scott (M., D. or other) _____
Address Harrisonville Mo Date signed July 9-43

Physician
Underline the cause to which death should be charged statistically.

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

9
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0

STATE BOARD OF HEALTH
PHYSICIAN'S OFFICE

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

working under my personal supervision.

Registered Apprentice No.

Signed

Ernest R. Cunningham

Licensed Embalmer No. 3368

P. O. Address *Harrisonville, 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, above space should be left blank.

PROPERTY OF
STATE BOARD OF HEALTH
PHYSICIAN'S OFFICE

State File No. _____
Registrar's No. 131

Registration District No. 59 Primary Registration District No. 4097

PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County... Cass

(b) City or town... Harrisonville
(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 years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Elysi Jane Russell

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color of race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 3
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 2
If less than one day, min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

(a) Informant _____

(b) Address _____

(a) _____ (b) _____
(Burial, cremation, or removal) (Date thereof) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 18 Year 1948 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction with systemic coronary atherosclerosis

Due to Abraemia was due to chronic nephritis

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? _____
(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 J M South (M. D. or other) _____
Address Harrisonville Date signed July 27

SUPPLEMENTAL

INTERNATIONAL

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

131

S-24659

Handwritten

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