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FORM-5-4
5-17-49
X-2875

29511

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED AUG 24 1949

Registration District No. 236

Primary Registration District No. 6130

Registrar's No.

1. PLACE OF DEATH

(a) County Shannon

(b) City or town Emmerson, Mo. W. I.

(c) Name of hospital or institution Rural Jack Trpk 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 37 years (Specify whether years, months or days)

In this community 37 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon

(c) City or town Rural Jack Trpk
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Marvel Mills Russell

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8-10 day Aug
year 1949 hour 12.11 PM minute M.

4. Sex M

5. Color or race A

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

6. (b) Name of husband or wife Martha C. Leflin

6. (c) Age of husband or wife if alive 3 years 1873

7. Birth date of deceased Mar 3 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 4 1949 to Aug 10 1949
that I last saw him alive on Aug 9 1949
and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 8 Days 7
If less than one day --- hr. --- min.

Immediate cause of death Apoplexy

Due to 8/30

Due to ---

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

Other conditions Hypertension & Postitilis (Include pregnancy within 3 months of death) 1 1/2 yrs

10. Usual occupation Farmer

11. Industry or business ---

12. Name Maria Russell

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

14. Maiden name ---

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

PHYSICIAN ---

Major findings: Of operations ---

Of autopsy ---

Underline the cause to which death should be charged statistically.

16. (a) Informant Minnie P. Shelton

(b) Address Emmerson Mo

17. (a) Burial (Burial, cremation or removal) (b) Date thereof 8-10-49
(Month) (Day) (Year)

(c) Place: burial or cremation John G. Meaney

18. (a) Signature of funeral director John G. Meaney

(b) Address Emmerson Mo

19. (a) 8-10-49 (Date received local registrar) (b) Frank Boyd M.D. (Registrar's signature)

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 W. T. Euseby (M. D. or other) ---

Address Emmerson Date signed 8-10-49

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 843305-

Date Filed 8-23-43

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. *Not Embalmed*

Signed..... *John J. Amann*

Licensed Embalmer No. 25164

P. O. Address *Not Given 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Rural
(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 37 yr.
years, months or days

3. (a) PRINT FULL NAME Marnel Mills Russell
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

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

8. AGE: Years Months Days (less than one day) _____ min.

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

10. Usual occupation Shannon

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)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-10-43 (b) Frank H. de MW
(Date 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 Aug year 1943 hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

Other conditions _____
(include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

29514