S. No. 2
M—2-43
5-17-39
1 X35897

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39205

Registration District No. FILED NOV 20 1943

Primary Registration District No. 6076

Registrar's No. 25510

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

1. PLACE OF DEATH:

(a) County ST. LOUIS

(b) City or town Koch (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 163 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 17

(c) City or town ST. LOUIS (If outside city or town limits, write "RURAL")

(d) Street No. 715 N. COMPTON (If rural, give location)

(e) Citizen of foreign country? NO. (Yes or No)

If yes, name country /

3. (a) PRINT FULL NAME ZOLA RUSSELL

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race NEGRO

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

6. (b) Name of husband ~~or wife~~ CLIFFORD RUSSELL

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

7. Birth date of deceased 10 (Month) 8 (Day) 1912 (Year)

8. AGE: Years 31 Months 1 Days 6 If less than one day hr. min.

9. Birthplace LITTLE ROCK (City, town, or county) ARK. / (State or foreign country)

10. Usual occupation MAID

11. Industry or business —

FATHER
12. Name GILBERT MACON
13. Birthplace LITTLE ROCK (City, town, or county) ARK / (State or foreign country)

MOTHER
14. Maiden name BETTY HOGAN
15. Birthplace LITTLE ROCK (City, town, or county) ARK / (State or foreign country)

16. (a) Informant PATIENT

(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 18 43 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director Peoples Und. Co.

(b) Address 3100 Franklin Ave

19. (a) NOV 18 1943 (Date received local registrar) (b) E. G. McGavran, M. D. F. S. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14 year 1943 hour 11 minute 50 P M.

21. I hereby certify that I attended the deceased from 6 - 1 - 1943, to 11 - 14 1943 that I last saw her alive on 11 - 14 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	5½ yrs (?)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 13 P-1
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Israel S. Kaminsky (M. D. ~~or other~~)

Address Kale Hosp. Kale, MO Date signed 11/15/43

(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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....Jotie Pettus.....

Licensed Embalmer No. 4684

P. O. Address.....St. Louis, 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.