

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

FILED JAN 3 1944
Registration District No. **317**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **ST. LOUIS**
(b) City or town **MOCH**
(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 **507 DAYS**
In this community **507 DAYS**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **1019 A S. CARDINAL**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **MARY RUSSELL**

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

4. ~~MALE~~ **FEMALE** 5. Color or race **COLORED** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **LAURENCE S. RUSSELL** 6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **NOVEMBER 5 1907**
(Month) (Day) (Year)

8. AGE: Years **36** Months **1** Days **15** If less than one day **—** hr. **—** min.

9. Birthplace **?** (City, town, or county) **MISS. 1** (State or foreign country)

10. Usual occupation **COOK**

11. Industry or business

MOTHER FATHER { 12. Name **ANDREW BASHIN**
13. Birthplace **?** (City, town, or county) **MISS. 1** (State or foreign country)
14. Maiden name **EVELENA DORRIS**
15. Birthplace **?** (City, town, or county) **MISS. 1** (State or foreign country)

16. (a) Informant **PATIENT**

(b) Address **ROBERT KOCH HOSPITAL**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **12-28-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Washington PK English Und. Co**

18. (a) Signature of funeral director **English Und. Co**

(b) Address **2931 Lushy**

19. (a) **DEC 28 1943** (Date received local Registrar) **C. Mc Gowan MD** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DECEMBER** day **20** year **1943** hour **12** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **JULY 28** 19**42** to **DECEMBER 20** 19**43**; that I last saw him **alive on** **19** and that death occurred on the date and hour stated above.

Immediate cause of death **PULMONARY T.B.C.** 20 HOURS?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **13th**

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 **Bernard Friedman** (M. D. or other) **M.D.**

Address **1600 1/2 1st St, mo** Date signed **12-24-43**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

JAN 18 1944

Handwritten notes and signatures, including "L. Lucas" and "Lucas" visible.

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 *Bulson English*.....

Licensed Embalmer No. *4208*.....

P. O. Address *2931 Lucas Ave*.....

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.