DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7689

Registration District No. 193 — Primary Registration District No. 5709 — Registrar's No.

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

1. PLACE OF DEATH:

(a) County MCDonald

(b) City or town Rural Erie TWP. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Goodman Mo (If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED: 60

(a) State Missouri (b) County MCDonald

(c) City or town Goodman MO. (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 0

3. (a) PRINT FULL NAME CLETA COLLEEN 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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. (Month) 21. (Day) 1943 (Year)

8. AGE: Years 0 Months 4 Days 1 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name Iven Russell
13. Birthplace OKLA (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ethel Harvey
15. Birthplace (City, town, or county) NewMexico (State or foreign country)

16. (a) Informant Iven Russell
(b) Address Goodman MO.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation Howard Cemetry

18. (a) Signature of funeral director Chas W Williams
(b) Address Goodman Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 22 year 1944 hour 10 minute 30A. M.

21. I hereby certify that I attended the deceased from Jan 22, 1944, to Jan 22, 1944 that I last saw her alive on Jan 22, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death puerperal hemorrhagica

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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 2

23. Signature C D James (M. D. or other) DO

Address Goodman Mo Date signed 1/23/44

464

(Licensed Embalmer's Statement on Reverse Side)

Officer No. 6,
Number 244-279
Date filed FEB 15 1944

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. MAR

Registration District No. 193 Primary Registration District No. 5709 Registrar's No.

1. PLACE OF DEATH:
(a) County McDonald
(b) City or town Rural Cyre Twp.
(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

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

3. (a) PRINT FULL NAME Cleta Colleen Russell
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Sept 21 1943 (Month) (Day) (Year)
8. AGE: Years Months 4 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name Iven Russell
13. Birthplace (City, town, or county) Okla. (State or foreign country)
MOTHER 14. Maiden name Ethel Hartley
15. Birthplace (City, town, or county) New Mexico (State or foreign country)
16. (a) Informant Iven Russell
(b) Address Goodman Mo
17. (a) (Burial, cremation, or removal) (b) Date thereof 1-23-44 (Month) (Day) (Year)
(c) Place: burial or cremation Howard Cemetery
18. (a) Signature of funeral director Chas W. Williams
(b) Address Goodman Mo.
19. (a) 2-10-44 (Date received local registrar) (b) Mark W. Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1944 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature C. D. Jame (M. D. or other) DO
Address Date signed

SUPPLEMENTARY

FILE

7689