

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 149 Primary Registration District No. 1602

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Wheatley Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Two days**
(Specify whether years, months or days) **Three Yrs.**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1809 E. II St**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Otis Henry Russaw**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **Negro**
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 **Oct. 6th. 1940**
(Month) (Day) (Year)

8. AGE: **3** Years **9** Months **25** Days
If less than one day _____ hr. _____ min.

9. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Child**

11. Industry or business _____

MOTHER FATHER

12. Name **Henry Albert Russaw**
13. Birthplace **Memphis Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Minnie Lee Cemer**
15. Birthplace **Kansas City Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Addie Russaw**
(b) Address **812 Euclid Ave**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **7-20-44**
(Month) (Day) (Year)
(c) Place: burial or cremation **Highland Cem**

18. (a) Signature of funeral director **Wheatley Hospital**
(b) Address **1905 Vine St**

19. (a) **7-28-44** (Date received local registrar)
(b) **T. E. Brown** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **15** day **July**
year **1944** hour **2** minute **55 P.M.**
21. I hereby certify that I attended the deceased from **July 11**, 19**44**, to **July 15**, 19**44**,
that I last saw him alive on **July 15**, 19**44**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) **107**
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: **H. M. Kelly** (M. D. or other)
Address **1624 Rm. Old** Date signed _____

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

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.....

[Handwritten Signature]
.....
Licensed Embalmer No. *2710*
P. O. Address *15.0 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.