

FILED AUG 3 1944

State File No. _____
Registrar's No. 780

Registration District No. 70

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 7 Mo. 6 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2343 Woodland
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Russell

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

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced, wid-
2

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

7. Birth date of deceased Aug 31 1885
(Month) (Day) (Year)

8. AGE: Years 88 Months 10 Days 27 If less than one day hr. _____ min. _____

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

10. Usual occupation Coal Miner

11. Industry or business _____

MOTHER FATHER
12. Name not given
13. Birthplace not given
(City, town, or county) (State or foreign country)
14. Maiden name not given
15. Birthplace not given
(City, town, or county) (State or foreign country)

16. (a) Informant Record Hospital
(b) Address St Joseph Mo

17. (a) BURIAL (b) Date thereof 7/31/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director [Signature]
(b) Address Kansas City, Mo

19. (a) 7/31/44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
year 1944 hour 6:50 minute 4-M.

21. I hereby certify that I attended the deceased from 7/28 1944 to July 28 1944
that I last saw him alive on July 27 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to arteriosclerosis

Due to _____
Other conditions Psychosis
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy 94a
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 [Signature] (M. D. or other) _____
Address St Joseph Mo 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, ~~by~~.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *George M. Collier*
Licensed Embalmer No. *3839*
P. O. Address *Indep 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.