. S. No. 2
M—8-43
v. 5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36355

FILED DEC 9 1944

Registration District No. 318

Primary Registration District No. 1005

Registrar's No. 10181

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Isolation Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11/25/44 to 11/26/44 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County

(c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 3127 Locust. St
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sam R. Russell.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex White

5. Color or race Male

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

6. (b) Name of husband or wife

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

7. Birth date of deceased July 5th., 1880
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 ~~Days 19~~ 21 If less than one day hr. min.

9. Birthplace ? (City, town, or county) Ky. (State or foreign country)

10. Usual occupation ?

11. Industry or business ?

FATHER
12. Name Chas. Russell
13. Birthplace ? (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Louise Ross
15. Birthplace ? (City, town, or county) Ky. (State or foreign country)

16. (a) Informant Stella Grady.
(b) Address 5600 Arsenal Sy.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-29-44 (Month) (Day) (Year)
(c) Place: burial or cremation Louisville Ky.

18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.

19. (a) NOV 29 1944 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 26th year 1944 hour 2 minute 10 A.M.

21. I hereby certify that I attended the deceased from 11/25 44, 19 , to 11/26, 19 44 that I last saw him alive on 11/26, 19 44 and that death occurred on the date and hour stated above.

Immediate cause of death ~~Meningitis~~ Pneumoccic meningitis
Chronic otitis media, right

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.

89a

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 R W Maxwell (Dr Case M.D.) (M. D. or other)

Address Isolation Hospital Date signed 11-29

(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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.