

Registration District No. 97

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Howell
(b) City or town West Plains, Mo
(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 1 (Specify whether

In this community 6 months years, months or days)

3. (a) PRINT FULL NAME Wm Albert Russell

3. (b) If veteran, name war... 3. (c) Social Security No. 2

4. Sex mp 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Martha Moore 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased Oct 28 (Month) (Day) (Year)

8. AGE: 60 Years Months Days If less than one day min.

9. Birthplace Howell Co., Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name W.B. Russell
13. Birthplace Crawford Co., Mo (City, town, or county) (State or foreign country)

{ 14. Maiden name Rebecca Russell
15. Birthplace Howell Co., Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carl Russell
(b) Address Houseas City, Mo

17. (a) 10 (b) Date thereof 10/5/44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Hill

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo

19. (a) 11-5-44 (b) Albert Russell (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")

(d) Street No. 115W. Main (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 30 year 44 hour 6 minute pm

21. I hereby certify that I attended the deceased from 8/15/44 19. to 9/30/44 19. that I last saw h. im alive on 9/28/44 19. and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, Chr. pulmonary
Due to T.B. Infection
Due to 13 1/2
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature A.H. Thornburgh (M. D. or other) 12/4/44
Address West Plains, Mo. Date signed

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

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1

Thornburgh

RECEIVED

District Health Officer No. 5,

District File Number 1244601

Date Filed 12-8-44

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. 3435

P. O. Address.....

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.