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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 25 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 59

Primary Registration District No. 4097

Registrar's No. 4

1. PLACE OF DEATH: Cass

(a) County Cass

(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution: _____
In this community 41 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cass 19

(c) City or town Harrisonville
(If outside city or town limits, write "RURAL.")

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME John Thomas Russell

3. (b) If veteran, name war V

3. (c) Social Security No. V

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 6
year 1945 hour 1 minute 30A M.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Psychalene Russell

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

7. Birth date of deceased June 10, 1860
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 3 - 1945 to Jan 6, 1945
and that I last saw him alive on _____, 19____
and that death occurred on the date and hour stated above.

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

84 6 26 hr. min.

Immediate cause of death: Uraemic Coma
Nephritis

Due to _____

Due to _____

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

10. Usual occupation Retired Farmer

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name George Russell

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

14. Maiden name Nancy Russell

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

16. (a) Informant Mrs Jesse Haymond

(b) Address Archie, Mo.

17. (a) Burial (b) Date thereof 1-8-45
(Burial, cremation or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Freeman, Mo

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) (c) Means of injury _____

23. Signature J. A. Scott (M: D. or other) _____
Address Harrisonville Mo Date signed Jan 6, 45

18. (a) Signature of funeral director Brunnenburger's

(b) Address Harrisonville, Mo.

19. (a) Jan. 6, 1945 (b) Margaret Tolle
(Date received local registrar) (Registrar's signature)

127 Scott 1047 (Licensed Embalmer's Statement on Reverse Side)

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..... *Ernest Runnenburger*

Licensed Embalmer No. *3368*

P. O. Address *Harrisonville 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.

Registration District No. *59*

Primary Registration District No. *4087*

Registrar's No. *4*

1. PLACE OF DEATH:
 (a) County *Cass*
 (b) City or town *Harrisonville*
(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
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME *John J. Russell*
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *m* 5. Color or race *w*
 6. (a) Single, widowed, married, divorced *w*
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: *June 10 1896*
(Month) (Day) (Year)

8. AGE: Years *84* Months *6* Days _____
(Unless than one day) min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Jan* year *1945* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to *Chronic Nephritis*

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 *John J. Russell* (M.D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

S-1950