

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED MAR 14 1945

Registration District No. **818** Primary Registration District No. **1003** Registrar's No. **201**

1. PLACE OF DEATH:

(a) County St. Louis

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

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

(d) Length of stay: In hospital or institution 8 days
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Marion

(c) City or town Salem
(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 _____

3. (a) PRINT FULL NAME Jesse Russell Vursell

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Allie Vursell

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased July 18 1883
(Month) (Day) (Year)

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

61	7	10	hr. min.
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9. Birthplace Marion County Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Tavern Operator

11. Industry or business _____

12. Name Henry Vursell

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

14. Maiden name Unknown

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

16. (a) Informant Allie Vursell

(b) Address Salem, Ill.

17. (a) Removal (b) Date thereof 3-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem, Illinois

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) Map (b) J. F. Budde
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 28
year 1945 hour 11 minute 15 p.m.

21. I hereby certify that I attended the deceased from Feb. 22 1945 to Feb. 28 1945
that I last saw him alive on Feb. 28 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute monocytic leukemia

Due to _____

Due to _____

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 F. R. Budde (M. D. number) _____
Address Barnes Hospital Date signed 3/1/45

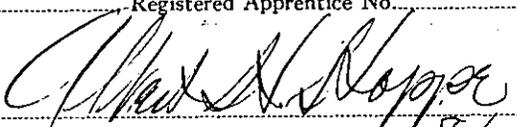
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed..... 

..... Licensed Embalmer No. 1861

..... 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.