V. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 30 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9703

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 208

1. PLACE OF DEATH:

(a) County GREENE

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

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

(d) Length of stay: In hospital or institution 9 weeks (Specify whether years, months or days)
In this community 2 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster

(c) City or town Marshfield 11
(If outside city or town limits, write "RURAL")

(d) Street No. x 1
(If rural, give location)

(e) Citizen of foreign country? No 1 (Yes or No)
If yes, name country x

3. (a) PRINT FULL NAME Josephine Russell

3. (b) If veteran, name war None

3. (c) Social Security No. UNK

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased March (Month) - 10 (Day) - 1874 (Year)

8. AGE: Years 71 Months 0 Days 2 If less than one day x hr. x min.

9. Birthplace Laclede County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Matron

11. Industry or business School

FATHER
12. Name F. M. Russell
13. Birthplace UNK Missouri 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nancy Daniels
15. Birthplace UNK. Tennessee 1 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Florence Corbett (sister)
(b) Address Marshfield, Mo.

17. (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3 (Month) - 14 (Day) - '45 (Year)
(c) Place: burial ~~or cremation~~ Conway, Missouri

18. (a) Signature of funeral director Ex Rainey
(b) Address Marshfield, Missouri

19. (a) 3-14-45 (Date received local registrar) (b) S W E Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 12 year 1945 hour 7 minute 10 P.M.

21. I hereby certify that I attended the deceased from Dec. 29, 1944, to 3/12, 1945 that I last saw her alive on 3/12, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Ovary	3 mo
Due to with Generalized Metastasis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 4 a.m.	
Major findings: Of operations as per above	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Guy D Calloway (M. D. or other) MD
Address Springfield, Mo. Date signed 3/12/45

(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 Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.