No. 2
1—2-43
5-17-39
I X35597

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

27567

State File No.

FILED AUG 20 1945

Registration District No. 22

Primary Registration District No. 42-45573A

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: Mt Hope Ry 2½ mi. S. West 1 (If not in hospital or institution, write street number or location)

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

In this community 25 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Independence (Rural) (If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. 2 (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

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

3. (b) If veteran, name war No

3. (c) Social Security No. 2554

4. Sex Mo

5. Color or race W

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

6. (b) Name of husband or wife Helen

6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased July (Month) 21 (Day) 1920 (Year)

8. AGE: Years 25 Months 0 Days 2 If less than one day hr. min.

9. Birthplace Grain Valley Mo (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Russell
13. Birthplace Jackson Co Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Webb
15. Birthplace Jackson Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Doris Stanfield

(b) Address R. 2 Independence Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director Mrs G R Webb & Son

(b) Address Blue Springs Mo

19. (a) 7-29-1945 (Date received local registrar) (b) Mrs Jessie M. Histon (Registrar's signature)

1560

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 23 year 1945 hour 7:00 minute P M.

21. I hereby certify that I attended the deceased from Coroner, 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Gun shot wound of abdomen.	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy No Permit History & Inspection

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) Don't Know

(b) Date of occurrence 7-23-45

(c) Where did injury occur? Oak Grove, Jackson, Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place (Specify type of place)

While at work? no (e) Means of injury 12 Gauge shot

23. Signature James C Walker 3 (M. D. or other) Coroner

Address 1424 Jefferson Mdy Date signed 7-26-45

(Licensed Embalmer's Statement on Reverse Side)

NOV 6 19..

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 R B Webb

Licensed Embalmer No. 2353

P. O. Address Blue Springs

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.

S. No. 2B
5M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 152 Primary Registration District No. 5573A Registrar's No. 14

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Rural Sni A Bar Twp
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(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

3. (a) PRINT FULL NAME Clyde R. 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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased July 21 1922
(Month) (Day) (Year)

8. AGE: Years 25 Months 0 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month July 23
year 1945 hour 5 minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Gun Shot wound of Abdomen	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No Permit
History & Inspection

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) Don't Know

(b) Date of occurrence 7-23-45

(c) Where did injury occur? Oak Grove Jackson County
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place
(Specify type of place)

While at work? (e) Means of injury 12Gauge Shot-Gun

23. Signature Dr. Jas. C. Walker, Coroner (M. D. or other)

Address 1424 Professional Bldg Date signed 7-26-45

SUPPLEMENTARY

5-27567

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NOV 6 1945