

S. No. 2
M-1-4-41
v. 5-17-39
WI X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED SEP 7 1945

STANDARD CERTIFICATE OF DEATH

State File No. 28702

Registration District No. 340

Primary Registration District No. 6152

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Dexter Rural
(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 5 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Dexter--Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Leon Russell

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased October 17 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 14 hr. min.

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

10. Usual occupation none

11. Industry or business _____

12. Name Leo Russell

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

14. Maiden name Georgia Maze

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

16. (a) Informant Leo Russell

(b) Address Kalamazoo, Mich

17. (a) Burial (b) Date thereof 9/2/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elliott Cemetery

18. (a) Signature of funeral director Watkins Funeral Ser.

(b) Address Dexter Mo

19. (a) 9-2-45 (b) Carlie Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 31
year 1945 hour 9 minute 05 P. M.

21. I hereby certify that I attended the deceased from 8-31-1945 to 8-31-1945
that I last saw him alive on 8-31-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Polioencephalitis Duration 2 days

Due to _____

Due to _____

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 Russell Ryan (M. D. or other) _____

Address Bermit Ind Date signed 9-2-45

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

RECEIVED

District Health Office No. 2

District File Number ⁹⁴⁵ 299 30

Date Filed 9-6-45

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 *Lyman Steele*

Licensed Embalmer No. *7476*

P.O. Address *Hester M*

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.