

S. No. 2
1-843
5-17-39
PI X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40706

State File No.

Registration District No. 16

Primary Registration District No. 5151

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Rural Kidder township
(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 years, months or days) 50 yrs.

3. (a) PRINT FULL NAME BORA ANN RUSSELL

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife J. R. Russell 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased JAN 24 1893
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business Housekeeping

12. Name George Shearman

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

14. Maiden name Elizabeth Mathews

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

16. (a) Informant J. L. Russell

(b) Address Cameron Mo.

17. (a) Burial (b) Date thereof Dec 29 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McDaniel Crying

18. (a) Signature of funeral director S. E. Moss

(b) Address Cameron Mo.

19. (a) Dec 29-46 (b) Fred P. Bridgewater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Caldwell

(c) City or town Rural Kidder township
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27
year 1945 hour 6 minute 30 a.m.

21. I hereby certify that I attended the deceased from Jan 1944 to Dec 27 1945
that I last saw him alive on Dec 27 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____

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) _____ (Means of injury)

23. Signature [Signature] (M. D. or other) _____

Address [Address] Date signed 12/29/45

RECEIVED
District Health Officer No. 11,
District File Number _____
Date Filed _____

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 not

working under my personal supervision.

Registered Apprentice No. _____

Signed Lois M. Brent

Licensed Embalmer No. 2533

P. O. Address Conover, 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.