No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13980

Registration District No. 243 Primary Registration District No. 5837 Registrar's No. 46

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution:
ASF Regional Station Hospital 0
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Massachusetts (b) County unknown 999

(c) City or town New Bedford 10
(If outside city or town limits, write "RURAL")

(d) Street No. 219 Ash Street 10
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 2

If yes, name country ------

3. (a) PRINT FULL NAME Elliott F. Russell

3. (b) If veteran, name war none

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Joan Russell

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

7. Birth date of deceased August (Month) 9 (Day) 1927 (Year)

8. AGE: Years 18 Months 8 Days 19 If less than one day -- hr. -- min.

9. Birthplace New Bedford, (City, town, or county) Mass. / (State or foreign country)

10. Usual occupation Soldier

11. Industry or business U. S. Army

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

MOTHER
14. Maiden name Frances, Russell
15. Birthplace Fall River (City, town, or county) Mass. / (State or foreign country)

16. (a) Informant Service Record, ASFTC Personnel
(b) Address Camp Crowder, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr 30, 1946 (Month) (Day) (Year)
(c) Place: burial or cremation New Bedford, Mass.

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.

19. (a) May 2, 1946 (Date received local registrar) (b) Melvin C. Bowman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28 year 1946 hour 6 minute 33 P.M.

21. I hereby certify that I attended the deceased from April 27, 1946 to April 28, 1946; that I last saw him alive on 28 April, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis, meningococal, subacute.

Due to

Due to

Other conditions 6
(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy Meningococcemia
Cerebro Spinal Meningitis

Duration

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 0

23. Signature James M. Foster MD (M. D. or other)

Address ASF Reg Sta Hosp, Cp Crowder, Mo. Date signed 4/29/46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No.

District File Number 546-73

Date Filed 5-13-46

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 Frank W Knell Jr, Registered Apprentice No. 379 working under my personal supervision.

Signed Emma L Knell

Licensed Embalmer No. 391

P. O. Address Carthage

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.