

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County St. Louis Mo
 (b) City or town St. Louis Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3023 N. Sarah
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 61 years years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County St. Louis
 (c) City or town St. Louis Mo
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3023 N. Sarah
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Joseph H. Russell
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 495-18-3152

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 Oct 16 1884
 (Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation Painter

11. Industry or business _____

MOTHER FATHER 12. Name John T. Russell

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

14. Maiden name Elizabeth Mueller

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

16. (a) Informant Elizabeth Russell

(b) Address 3023 N. Sarah

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/22/46 (Month) (Day) (Year)

(c) Place: burial or cremation Culver Cemetery

18. (a) Signature of funeral director J. F. Brebeck

(b) Address 1619 1/2 Franklin

19. (a) MAY 21 1946 (Date received local registrar) J. F. Brebeck (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May day 17th year 1946 hour 7 minute P M.
 21. I hereby certify that I attended the deceased from May 16 46 to May 17th 1946
 that I last saw him alive on May 16th 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis
 Due to followed Influenza
 Due to _____

Other conditions (Include pregnancy within 3 months of death) 33

Major findings: Of operations _____

Of autopsy _____

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) (or) Means of injury none
 23. Signature Oliver B. Kane (M. D. or other) MD
 Address 106 Walton Date signed 5/22/46

Duration 3 hrs
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

17727

DEC 11 1946

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..... *Gas A. Howard*

Licensed Embalmer No..... *4139*

P. O. Address..... *St Louis 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.