No. 2
1-5-43
5-17-39
X38671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10146

Registration District No. 243 Primary Registration District No. 4363 Registrar's No.

1. PLACE OF DEATH:

(a) County Newton

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

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ——— In this community 12 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73

(c) City or town Fairview, Mo. 0
(If outside city or town limits, write "RURAL")

(d) Street No. None 0
(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)
If yes, name country ———

3. (a) PRINT FULL NAME James Harvey Russell

3. (b) If veteran, name war ———

3. (c) Social Security No. ———

4. Sex Male 0

5. Color or race White

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

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

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

7. Birth date of deceased Nov. (Month) 1 (Day) 1886 (Year)

8. AGE: Years 60 Months 2 Days 2 If less than one day ___ hr. ___ min.

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation General laborer

11. Industry or business ———

FATHER
12. Name J. B. Russell
13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. O. O. Rodgers
(b) Address Fairview, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 (Month) 5 (Day) 47 (Year)
(c) Place: burial or cremation Dice Cemetery

18. (a) Signature of funeral director Wm Morris Pope
(b) Address Wheaton, Mo

19. (a) 4-10-47 (Date received local registrar) (b) Alpha Dyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 3 year 1947 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec 23 1946, to Dec 31 1946 and that I last saw him alive on Dec 31 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral embolism.	2 weeks
Due to Endocarditis	Not known
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 9 2 E

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 2

23. Signature Charles O. Christy (M. D. or other) M.D.
Address Grant City, Mo Date signed 1-9-47

(Licensed Embalmer's Statement on Reverse Side)

369

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. Wm Morris Pogue

Licensed Embalmer No. 5429

P. O. Address. Wheatland, 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.

No. 2B
—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. April

Registration District No. 243 Primary Registration District No. 4363 Registrar's No. 9

1. PLACE OF DEATH:
(a) County Newton
(b) City or town Fairview
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(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 James H. 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 wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov. 1 (Month) (Day) (Year)
8. AGE: Years 60 Months 2 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
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) 4-10-47 (Date received local registrar) (b) Alpha Dyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1947 hour 4 minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

10146