

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35420**

FILED OCT 31 1947

Registration District No. 314

Primary Registration District No. 6062

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County St. Clair
 (b) City or town Rural-Doyle Twp.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community Life years, months or days

3. (a) PRINT FULL NAME JERRY RAY 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 Aug. 14 1947
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>6</u> hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Joseph R. Russell

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

14. Maiden name Leather

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

16. (a) Informant Ina Rash
 (b) Address Collins Mo.

17. (a) Burial (b) Date there Aug. 15-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wynkard Cemetery

18. (a) Signature of funeral director E. H. Brown

(b) Address Humansville, Mo.

19. (a) 9-7-1947 (b) Keith Deeters
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair 93
 (c) City or town Rural 0
 (If outside city or town limits, write "RURAL")
 (d) Street No. Doyle Twp. 6
 (If rural, give location)
 (e) Citizen of foreign country? no 0 (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14
 year 1947 hour 6 minute _____ A. M.

21. I hereby certify that I attended the deceased from Aug 14
1947 to Aug 14 1947
 that I last saw her alive on Aug 14 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death congenital debility Duration _____

Due to _____

Due to _____

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

Major findings: _____
 Of operations SB

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 2

23. Signature D. E. D. Brown (M. D. or other) Do

Address Collins Mo. Date signed 8-19-1947

RECEIVED
District Health Officer No. 7,
District File Number 7-47-985
Date Filed 8-19-77

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.....

no embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
E. H. Pinner

Licensed Embalmer No. *4282*

P. O. Address *Humanville, 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.