

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

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FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 22 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 23150
2915
Registrar's No.

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 36 hours
In this community Non-Resident (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Carthage
(If outside city or town limits, write "RURAL")
R.R. #4
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3: (a) PRINT FULL NAME CLAUDE CECIL RUSSELL

3: (b) If veteran, name war unknown 440 2nd 900 806

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, 2 divorced Widowed

6. (b) Name of husband or wife Lena Russell 6. (c) Age of husband or wife if alive XX years

7. Birth date of deceased August 12 1902
(Month) (Day) (Year)

8. AGE: Years 45 Months 11 Days 2
If less than one day hr. min.

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

10. Usual occupation Employees

11. Industry or business Atlas Powder Co.

12. Name Charley Russell

13. Birthplace Pea Ridge Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Nora Roach

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

16. (a) Informant Dorothy Russell

(b) Address R #4 Carthage, Mo.

17. (a) Removal (b) Date thereof 7-15-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Collinsville, Okla

18. (a) Signature of funeral director J. W. Wagner
Kansas City, Mo.

(b) Address Kansas City, Mo.

19. (a) 7-15-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14
year 1948 hour 9: minute 30 P. 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.

Immediate cause of death Shock
Spinal Fracture
Auto Trauma
(2 Car Accident)
Due to _____
Due to _____
Other conditions (Include pregnancy within 9 months of death) Agently Coroner

Major findings: Of operations _____

Of autopsy History & Inspection

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident, 23
(b) Date of occurrence 7-15-48
(c) Where did injury occur? Jackson Jasper Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work No (Specify type of place) (e) Means of injury Trauma

23. Signature V.E. Usher (M. D. or other) MP-5
Address 2800 Main Date signed 7/14/48

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

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 Alvin R. Hausschild

Licensed Embalmer No. 4159

P. O. Address Kansas City

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2915

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Claude Cecil Russell

3. (b) If veteran, name war No ✓ 3. (c) Social Security No. 440-09-3806

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Heraldine Holme
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 1948 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ at _____ on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

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) _____ (e) Means of injury _____

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

Address _____ Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MISSOURI DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

S-2315D