

FILED OCT 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30548**
4184

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY JACKSON	
b. CITY OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST MARY'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 3915 CHESTNUT	

3. NAME OF DECEASED (Type or Print) a. (First) Nancy	b. (Middle)	c. (Last) Russell	4. DATE OF DEATH (Month) (Day) (Year) 9 27 49
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH SEPT 26, 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 2 Wks. Days	IF UNDER 4 Hrs. Hours	IF UNDER 15 Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ky	12. CITIZEN OF WHAT COUNTRY U.S.					

13a. FATHER'S NAME Wm. Vincent	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE JOHN RUSSELL
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME MRS. A.C. FRIEK	ADDRESS 3915 CHESTNUT
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis		1 mo
	ANTECEDENT CAUSES DUE TO (b) Adenocarcinoma Primary site unknown DUE TO (c)		4 mo
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION July 19, 49	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of abd. lymph glands	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 5, 1949**, to **Sept 27, 1949**, that I last saw the deceased alive on **Sept 27, 1949**, and that death occurred at **4:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Geo. C. Kealhofer (Deputy or title) M.D.	23b. ADDRESS 3447-Prospect K. C. Mo.	23c. DATE SIGNED 9-28-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-29-49	24c. NAME OF CEMETERY OR CREMATORY NEW HOPE	24d. LOCATION (City, town, or county) (State) HARDIN Mo
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DATE REC'D BY LOCAL REG. 9-29-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE SPINA + McCLURE	ADDRESS K.C. Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

L. J. Allen

Licensed Embalmer No. _____

1415

P. O. Address: _____

A E 2nd

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.