

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

8175

State File No.

DECEASED FEB 20 1953

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

BIRTH NO. _____		REG. DIST. NO. <u>17</u>		PRIMARY REG. DIST. NO. <u>541</u>		Registrar's No. <u>463</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u>		c. LENGTH OF STAY (In this place) <u>4 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WELLINGTON</u>		24181	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. LOUIS, CO. HOSPT</u>				d. STREET ADDRESS (If rural, give location) <u>1648 Lulu Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Leora</u> b. (Middle) <u>D</u> c. (Last) <u>Russell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 7 1953</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAY 31-1893</u>	
9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 WKS. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>CLINTON, KY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>GEORGE SMITH</u>			13b. MOTHER'S MAIDEN NAME <u>CAITIE CAMPBELL</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES RUSSELL Dec.</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>ANNA GERMER 5456 MAPLE</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral aneurysm</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Bronchial asthma acute</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Bronchial asthma chronic</u>					INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs.</u> <u>24 hrs.</u> <u>77 hrs.</u> <u>34 yrs.</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>241X</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 <u>2-4</u> , 19 <u>53</u> , to <u>2-7</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>53</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles E. Nichols M.D.</u>				23b. ADDRESS <u>601 S. Brentwood Clayton 5 Mo</u>		23c. DATE SIGNED <u>2-7-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>2/9/53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VAI HALL CEM</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, CO. MO.</u>	
DATE REC'D BY LOCAL REG. <u>2-7-53</u>		REGISTRAR'S SIGNATURE <u>Hubert R. Domb-M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. CLARK 1125 HODIAMONT</u>			

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

John S. Hennehy

Licensed Embalmer No. 4194

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.