

STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED MAR 31 1953
9 19 59

BIRTH NO. 91959 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2641

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Bluff, Mo 8030	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Mary's Infirmary		d. STREET ADDRESS (If rural, give location) R.R. 2 Box 281	
3. NAME OF DECEASED (Type or Print) a. (First) Calvin b. (Middle) Lewis c. (Last) Russ		4. DATE OF DEATH (Month) (Day) (Year) 2-22-53	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0	8. DATE OF BIRTH 12-11-52
9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) 9
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Leon Russ	13b. MOTHER'S MAIDEN NAME Alberta marrow	14. NAME OF HUSBAND OR WIFE 1-xx
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Leon Russ mother
		ADDRESS above

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration Pneumonia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prematurity DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Lymphadenopathy, Thyroid Hypertrophy		1 week	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 491X

22. I hereby certify that I attended the deceased from 12-11, 1952, to 2-22, 1953, that I last saw the deceased alive on 2-22, 1953, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS 1409 N. Crested	23c. DATE SIGNED 2-23-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 3-3-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REGISTRY MAR 10 1953	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service	ADDRESS
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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.....

Licensed Embalmer No.....

P. O. Address.....

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.