

STANDARD CERTIFICATE OF DEATH

WED AUG 25 1953 REG. DIST. NO. **355** PRIMARY REG. DIST. NO. **4520** Registrar's No. **19 Hampton**

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

1. PLACE OF DEATH a. COUNTY Texas		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, write RURAL and give township) Summersville, Mo		c. CITY (If outside corporate limits, write RURAL and give township): Summersville, Missouri 1070	
c. LENGTH OF STAY (to this place) 5 Years		d. STREET ADDRESS (If rural, give location) Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION None			
3. NAME OF DECEASED (Type or Print) a. (First) Carrie		b. (Middle) Russell	
c. (Last) Russell		4. DATE OF DEATH (Month) (Day) (Year) May 31 1953	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 18th
9. AGE (In years) (Month) (Day) 82		10. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME William Justice		13b. MOTHER'S MAIDEN NAME Louise Justice	
14. NAME OF HUSBAND OR WIFE Frank Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS D.D. Clouse Summersville, Mo	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterial Hypertension DUE TO (c) Chronic Valvular Disease of heart	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 443X	
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 May 15 1953 , that I last saw the deceased alive on May 15, 1953 and that death occurred at 11:25 pm , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. Lawrence Hampton, D.O.		23b. ADDRESS Summersville	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE June 2 1953		24c. NAME OF CEMETERY OR CREMATORY Flat Woods Cem,	
24d. LOCATION (City, town, or county) (State) Eminence, Mo		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anna Roberts 433-70 Duncan Funeral Home Mth View, Mo	
DATE REC'D BY LOCAL REG. 8-17-53		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Anna Roberts 433-70 Duncan Funeral Home Mth View, Mo	

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 *Joel P. Dunham*

Licensed Embalmer No. *4325*

P. O. Address *W. New York*

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.