

FILED APR 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11444**
Registrar's No. **30**

BIRTH NO. _____ REG. DIST. NO. **52** PRIMARY REG. DIST. NO. **5183**

1. PLACE OF DEATH
a. COUNTY **Cape Girardeau**
b. CITY OR TOWN **Rural - Jackson Byrd and**
c. LENGTH OF STAY (in this place) **LIFE**
d. FULL NAME OF HOSPITAL OR INSTITUTION **Route 1 Jackson, Mo.**

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
a. STATE **Missouri** b. COUNTY **Cape Girardeau**
c. CITY OR TOWN **R.F.D #1 Jackson 0160**
d. STREET ADDRESS (If rural, give location) **0**

3. NAME OF DECEASED (Type or Print)
a. (First) **Ella** b. (Middle) **Russell** c. (Last) **Anderson**

4. DATE OF DEATH (Month) (Day) (Year)
April 16 1954

5. SEX **F**

6. COLOR OR RACE **W**

7. MARRIED, NEVER MARRIED, 2
WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **July 19 1868**

9. AGE (In years last birthday) **85**

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours 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) **Cape Girardeau County**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Elliott Russell**

13b. MOTHER'S MAIDEN NAME **Delilah McCombs**

14. NAME OF HUSBAND OR WIFE **D. Robert Anderson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No**

16. SOCIAL SECURITY NO. **None**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Cross McHard R.F.D. Jackson 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, asphyxia, etc. It means the disease, injury, or complication which caused death.**

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Apoplexy**
ANTECEDENT CAUSES (b) **arteriosclerosis**
DUE TO (c)
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
1951

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? **334X**
YES NO

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) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 1957**, to **April 16, 1957**, that I last saw the deceased alive on _____, 19____, and that death occurred at **9:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **D. G. Schubert M.D.**

23b. ADDRESS **Jackson, Mo.**

23c. DATE SIGNED **4-16-57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **April 18, 1954**

24c. NAME OF CEMETERY OR CREMATORY **Old Appleton Cemetery**

24d. LOCATION (City, town, or county) (State) **Cape Girardeau Co. Mo.**

DATE REC'D BY LOCAL REG. **April 17-54**

REGISTRAR'S SIGNATURE **D. G. Schubert** 43

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **McCombs Fun. Serv. Co. Jackson Mo.**

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 B. A. Meyer

Licensed Embalmer No. 30571

P. O. Address Jackson 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.