

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 146Primary Registration District No. 3026Registrar's No. 124

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hall Drug. Co.		Length of stay in lb 2 yrs.	d. STREET ADDRESS (If outside, give location) 1421 Brookside		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) RUSSELL			4. DATE OF DEATH Mar. 20, 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1888	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouseman		10b. KIND OF BUSINESS OR INDUSTRY A.&P. Grocery	11. BIRTHPLACE (City and state or country) Dawn, Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johnathan Rea			14. MOTHER'S MAIDEN NAME Christina Loffert		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 500-28-6293	17. INFORMANT Address Mrs. Kathryn Rea, Independence, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion					INTERVAL BETWEEN ONSET AND DEATH 2 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) Arteriosclerosis					2 years
DUE TO (c) Hypertension					3 years
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) 4201					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from Sept 1955 to March 20 1957 and last saw her alive on Mar 19, 1957 Death occurred at 4 20 m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE RH Boyd Jr		(Degree or title) D.O.	22b. ADDRESS 9529 TRUMAN RD INDEPENDENCE MO	22c. DATE SIGNED 3/21/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar. 22, 1957	23c. NAME OF CEMETERY OR CREMATORY Plymouth Cemetery	23d. LOCATION (City, town, or county) (State) Braymer, Missouri		
24. FUNERAL DIRECTOR ADDRESS George C. Carson, Independence, Mo.		25. DATE RECD. BY LOCAL REG. 3-22-57	26. REGISTRAR'S SIGNATURE [Signature]		

(Licensed Embalmer's Statement on Reverse Side)

securing the medical certification in the specific manner required by 193.140 MOCS 1947.

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health,
Welfare
Public
ServiceS. 300
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9002

MAR 25 1957

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
Signature of Student Embalmer

Signed *H. Gibson*

Licensed Embalmer No. *4871*

P. O. Address *Indep. M.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.