

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-046246

STATE FILE NUMBER

318

1003

11706

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY Saint Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis Inside Limits\* Yes  No  c. CITY OR TOWN Saint Louis Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4481 San Francisco Length of stay in lb \_\_\_\_\_ d. STREET ADDRESS (If outside, give location) 4481 San Francisco Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year  
Minnie Lee Russell December 1, 1958

5. SEX Female 6. COLOR OR RACE Negro 7. MARRIED  NEVER MARRIED  WIDOWED  DIVORCED  8. DATE OF BIRTH April 9, 1903 9. AGE (In years last birthday) 55 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 (City and state or country) Columbus, Mississippi 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Gus Slater 13b. MOTHER'S MAIDEN NAME Dora Whitfield 14. NAME OF HUSBAND OR WIFE John Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT John Russell Address 4481 San Francisco

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Carcinoma of Colon  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) \_\_\_\_\_  
DUE TO (c) 153.P  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) \_\_\_\_\_  
INTERVAL BETWEEN ONSET AND DEATH ?

20a. ACCIDENT  SUICIDE  HOMICIDE  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  NOT WHILE AT WORK  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 11/5/58 to 12/1/58 and last saw her alive on 12/1/58  
Death occurred at 3 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. E. Rogers M.D. 22b. ADDRESS 3136 Chautau 22c. DATE SIGNED 12/5/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 12-5-1958 23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS E. D. Rooney 1221 N. Grand 25. DATE RECD. BY LOCAL REG. DEC 4 '58 26. REGISTRAR'S SIGNATURE Carl Smith MO 1180

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300

1-57

0-1000, 10000, etc. must show any standard nomenclature in their No. No symptoms when so stated. All diseases in Part I must be causally related.

**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 *[Handwritten Signature]* .....

Licensed Embalmer No. *475-8* .....

P. O. Address *17-511 N. Main* .....

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.