

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015652

STATE FILE NUMBER

2 3575

FILED MAY 7 1959

Registration District No.

Primary Registration District No.

Registrar's

300
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis,</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>St. Louis-Little Rock</u> c. INSTITUTION <u>Hospitals, Inc.</u>		Length of stay in lb <u>21 days</u>	d. STREET ADDRESS <u>2511 (If outside, give location) -2619 Summit Ave.,</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elvis</u> Middle <u>Franklin</u> Last <u>Russell</u>			4. DATE OF DEATH Month <u>April</u> Day <u>9,</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1901</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		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) <u>Locomotive Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Sandusky, Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Harry Russell</u>	
13b. MOTHER'S MAIDEN NAME <u>Jane Smalling</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>708-09-2930</u>	17. INFORMANT <u>Mrs. Ruth Russell</u> Address <u>111 2511 Summit, E. St. Louis,</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Carcinoma of lung, left</u> DUE TO (c) <u>163x</u> 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 <u>few days</u>
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. _____		ITEM <u>2d</u> CORRECTED BY AFFIDAVIT OF <u>Funeral Director</u> <u>5-13-59</u>	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>March 20, 1959</u> to <u>April 9th 1959</u> and last saw ^{her} <u>him</u> alive on <u>April 9th 1959</u> . Death occurred at <u>9:25 P.M.,</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R.C. Tremon M.D.</u> (Degree or title)		22b. ADDRESS <u>No. Phc. Hospital 1755 So. Grand Blvd.,</u>	
22c. DATE SIGNED <u>4/10/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>4-12-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>
23d. LOCATION (City, town, or county) <u>Percy, Illinois</u>		(State)	
24. FUNERAL DIRECTOR <u>Kurrus Funeral Home</u>		ADDRESS <u>E. St. Louis, Illinois.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 10 '59</u>
26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

mje

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 *C. J. Thomas Jr*
Licensed Embalmer No. *3162*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.