

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014058

FILED VS APR 20 1960

Registration District No. 002 Primary Registration District No. 504 Registrar's No. 29130 STATE FILE NUMBER

INDEXED

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ANDREW</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> COUNTY <u>ANDREW</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Empire Township</u>		Length of stay in 1b		c. CITY OR TOWN <u>RFD # 3 Savannah</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9 mi NE Savannah</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>9 miles northeast</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN BEDFORD RUSSELL</u>				4. DATE OF DEATH Month Day Year <u>April 12, 1960</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>5-13-97</u>		9. AGE (last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (City and state or country) <u>Douglas, Wyoming</u>			12. CITIZEN OF WHAT COUNTRY <u>U S A</u>					
13a. FATHER'S NAME <u>J. B. Russell</u>				13b. MOTHER'S MAIDEN NAME <u>Libbie S. Frazier</u>				14. NAME OF HUSBAND OR WIFE <u>Beatrice Russell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>491-42-3013</u>		17. INFORMANT Address <u>RFD # 3</u> <u>Mrs. Beatrice Russell Savannah, Mo.</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>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 <u>November</u> to <u>April 12-1960</u> and last saw ^{her} him alive on <u>April 12-1960</u> Death occurred at <u>7:20A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Dr. R. Wilson M.D.</u>						22b. ADDRESS <u>Boonville Mo</u>			22c. DATE SIGNED <u>4-12-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>4-14-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Savannah, Missouri</u>						
24. FUNERAL DIRECTOR ADDRESS <u>BREIT & HAWKINS SAVANNAH</u>				25. DATE RECD. BY LOCAL REG. <u>4-16-60</u>		26. REGISTRAR'S SIGNATURE <u>Kellian Spant</u>							

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 5, 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James B. Hawken

Licensed Embalmer No. 4536

P. O. Address Savannah

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.