

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015612

FILED VS MAY 9 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2236 STATE FILE NUMBER

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 Kansas City		Length of stay in 1b 55 years	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5808 Rockhill Road Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Rosie Middle Pearl Last Russell			4. DATE OF DEATH Month April Day 20 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/21/1890	9. AGE (last birthday) 70	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Cameron Missouri		12. CITIZEN OF WHAT COUNTRY U S A
13a. FATHER'S NAME John W. Davis		13b. MOTHER'S MAIDEN NAME Elizabeth Swearingine		14. NAME OF HUSBAND OR WIFE Burt Russell		
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. 487-01-3201		17. INFORMANT Kansas City Missouri Glen A. Russell 5808 Rockhill Road		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia		INTERVAL BETWEEN ONSET AND DEATH 5 mins.
DUE TO (b) Arteriosclerotic Heart Disease 6 Years.		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). ① Fracture of left Hip. ② Toxic Psychosis. ③ Chronic Asthmatic Bronchitis ④ Pulmonary Emphysema.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell at Front Door - stumbled - Landing on Hip. Feb. 27, 1960
20c. TIME OF INJURY Hour 7:00 p.m. Month, Day, Year 2-27-1960		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION Kansas City	COUNTY Jackson	STATE Mo.
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21. I attended the deceased from **January 1951** to **April 20, 1960** and last saw ^{her}him alive on **April 19, 1960**
Death occurred at **6:00 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Phillip G. Kaul M.D.	22b. ADDRESS 711 Nichols Road	22c. DATE SIGNED 4-20-1960
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/23/1960	23c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR D.W. Newcomers Sons 1331 Brush Creek Blvd.	25. DATE RECD. BY LOCAL REG. 4-21-60	26. REGISTRAR'S SIGNATURE Neva Minshall
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Kansas City Missouri

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Phillip G. Kaul

STATEMENT BY LICENSED EMBALMER

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 Chester K. Brown

Licensed Embalmer No. 4937

P. O. Address K P M

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.