

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VSV SEP 7 1960

60-033167

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 2497

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u>		c. CITY OR TOWN <u>WEBSTER GROVES</u>	
Length of stay in 1b <u>14 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>809 CROFTON AVE</u>		d. STREET ADDRESS (If outside, give location) <u>809 CROFTON AVE</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>AGNESS</u> Last <u>RUSSELL</u>			4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1884</u>	9. AGE (last birthday) <u>76</u>	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) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>SPRINGFIELD MO</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>THOMAS W CAMPBELL</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA VIRGINIA GRAVES</u>	
14. NAME OF HUSBAND OR WIFE <u>JOSEPH B RUSSELL, DECD</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>NONE</u>	
17. INFORMANT <u>Hugh F Russell</u>		Address <u>7559 Leendale Ave</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>	DUE TO (b) <u>Cerebral Arteriosclerosis</u>	<u>Immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m.	Month, Day, Year _____		

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
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21. I attended the deceased from 1958 to Aug 22 1960 and last saw her live on Aug 20 1960
 Death occurred at 6:50 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ed Deabough MD</u>		22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>8/22/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-24-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION COM</u>	23d. LOCATION (City, town, or county) <u>AFTON</u>	(State) <u>MO</u>
24. FUNERAL DIRECTOR <u>MITTELDERS</u>	ADDRESS <u>Webster Groves Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-22-60</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy MD</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Elton R. Remeis

Licensed Embalmer No. 4283

P.O. Address St. Louis

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