

DEAD DOCUMENT MEDICAL CERTIFICATION AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		c. CITY OR TOWN St Louis Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5716 Goodfellow Ave		d. STREET ADDRESS (If outside, give location) 5716 Goodfellow Ave	

3. NAME OF DECEASED (Type or print) First Robert Middle F Last Russell Jr			4. DATE OF DEATH Month 10 Day 8 Year 60		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-8-1886	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fire Captain		11. BIRTHPLACE (City and state or country) St Louis Mo		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Robert F. Russell		13b. MOTHER'S MAIDEN NAME Catherine Burns		14. NAME OF HUSBAND OR WIFE Leona	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give <u>year</u> dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Leona Russell 5716 Goodfellow Ave
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Cerebral arteriosclerosis		
DUE TO (c) Generalized Arteriosclerosis		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus		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	
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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.) 332x
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20c. TIME OF INJURY Hour a.m. p.m.	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY St Louis	STATE Mo
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21. I attended the deceased from Feb 4 1959 to Oct 8 1960 and last saw him alive on Oct 6, 1960
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Death occurred at **3 a** m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE H. Siesener MD	(Degree or title)	21b. ADDRESS Northland Med Bldg	21c. DATE SIGNED 10-8-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-11-1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St Louis Mo
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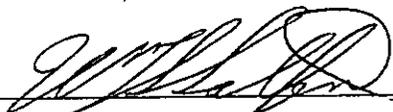
24. GENERAL DIRECTOR Arthur G. Donnelly	ADDRESS 3840 Lindell Blvd	25. DATE RECD. BY LOCAL REG. OCT 10 1960	26. REGISTRAR'S SIGNATURE H. L. H. MD
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Northland Medical Center

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 

Licensed Embalmer No. 4469

P. O. Address 38407

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.