

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041804

FILED VS DEC 12 1960

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 169 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in 1b <u>Mrs</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>Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>1005 N. Jefferson</u>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Francis</u> Last <u>Russell</u>			4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>60</u>		
---	--	--	---	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>8-27-78</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
-----------------	---------------------------	--	---------------------------------	----------------------------------	---	---

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 <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Boyles Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	---	---	--

13a. FATHER'S NAME <u>Henry Kisan</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Terian</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Russell</u>
---------------------------------------	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Frank Russell, West Plains Mo</u>	Address <u></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>Shock Neurogenic</u>	<u>7 HOURS</u>	
DUE TO (b) <u>Fracture, Right Hip</u>	<u>7 HOURS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u></u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROSIS @ SENILITY</u>	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
--	--

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.) <u></u>
--	---	---

20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year <u></u>
--	--------------------------

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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
---	--	---

21. I attested the deceased from 2-6-55 to 11-28-60 and last saw her alive on 11-27-60  
 Death occurred at 3:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul D. West</u> (Degree or title)	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>12-2-60</u>
--	------------------------------------	---------------------------------

23a. SURVIVAL OPERATION, REPAIR, or Specify <u></u>	23b. DATE <u>11-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Boal</u>	23d. LOCATION (City, town, or county) <u>Boal Mo</u>	23e. (State) <u>Mo</u>
---	---------------------------	--	--	------------------------

24. FUNERAL DIRECTOR <u>West Plains</u> ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>12-6-1960</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *D. S. Roberts*

Licensed Embalmer No. 343

P. O. Address *West 10*

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.