

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1960

-60-042259

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5437 STATE FILE NUMBER

IDED

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) Kansas City		Length of stay in lb 55 Yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 528 Donnelly			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 528 Donnelly		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W Last RUSSELL				4. DATE OF DEATH Month October Day 25 Year 1960				
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 10/30/78	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Sheffield Steel		11. BIRTHPLACE (City and state or country) Smithville Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Russell			13b. MOTHER'S MAIDEN NAME Lizzie Brechenridge		14. NAME OF HUSBAND OR WIFE Minnie 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. 487-05-3867A		17. INFORMANT Minnie Russell 528 Donnelly K.C. Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute congestive heart disease							INTERVAL BETWEEN ONSET AND DEATH 5 days	
DUE TO (b) cardiac asthma							3 yrs	
DUE TO (c) Bronchial asthma							20 yrs	
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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
21. I attended the deceased from Jan 3 - 1953 to Oct 25 - 1960 and last saw him alive on Oct 24 - 1960 Death occurred at Oct 25 - 1960 9:45 p m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) H. E. Schoen D O				22b. ADDRESS 3915 main st K.C. Mo			22c. DATE SIGNED 10-26-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/28/60	23c. NAME OF CEMETERY OR CREMATORY Mt Washington Cem		23d. LOCATION (City, town, or county) (State) Kansas City Missouri			
24. FUNERAL DIRECTOR Sheil Funeral Home K C Mo.			ADDRESS		25. DATE RECD. BY LOCAL REG. 10-28-60	26. REGISTRAR'S SIGNATURE H-L-Dwyer		

DOCUMENT

H. E. Schoen 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thomas A. Smith

Licensed Embalmer No. 4954
P. O. Address S.P. Mo

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