

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007971

AMENDED Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 48

STATE FILE NUMBER

FILED MAR 24 1961

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CASS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>CASS</b> |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>HARRISONVILLE</b>               |  | Length of stay in lb<br><b>10 Wks</b>   | c. CITY OR TOWN <b>HARRISONVILLE</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                       |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>MEMORIAL HOSPITAL</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>MEMORIAL HOSPITAL</b><br>Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <b>DELLA</b> Middle <b>ANN</b> Last <b>RUSSELL</b> | 4. DATE OF DEATH<br>Month <b>MARCH</b> Day <b>12</b> Year <b>1961</b> |
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|                      |                               |   |                                    |                                  |  |  |
|----------------------|-------------------------------|---|------------------------------------|----------------------------------|--|--|
| 5. SEX <b>FEMALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>11/28/1880</b> | 9. AGE (last birthday) <b>80</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|----------------------|-------------------------------|---|------------------------------------|----------------------------------|--|--|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOME*MAKER</b> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country)<br><b>HARRISONVILLE, MO.</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
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| 13a. FATHER'S NAME<br><b>J.R. VANDENVENTER</b> | 13b. MOTHER'S MAIDEN NAME<br><b>MARY A. HOLLOWAY</b> | 14. NAME OF HUSBAND OR WIFE<br><b>WILL RUSSELL</b> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 17. INFORMANT<br><b>Mrs W.E. Simmons</b><br>Address <b>5486 S. Elmwood St. Littleton, Colo.</b> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ADOMINAL CARCINOMATOSIS</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 MONTHS</b>   |
| DUE TO (b) <b>PRIMARY CARCINOMA RECTUM</b>   |  |   |
| 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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>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.) |
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|  |  |  |                       |                          |
|--|--|--|-----------------------|--------------------------|
| 20c. TIME OF INJURY<br>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<br><b>HARRISONVILLE</b> | COUNTY<br><b>CASS</b> | STATE<br><b>MISSOURI</b> |

21. I attended the deceased from 12 15 1957 to 12 MAR 1961 and last saw her live on 12 MARCH 1961  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE<br><i>[Signature]</i> (Degree or title)<br><b>MD</b> | 22b. ADDRESS<br><b>HARRISONVILLE MO</b> | 22c. DATE SIGNED<br><b>13 MAR 1961</b> |
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|  |                               |  |   |
|--|-------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>3/14/1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ORIENT CEMETERY</b> | 23d. LOCATION (City, town, or county) (State)<br><b>HARRISONVILLE, MISSOURI</b> |
|--|-------------------------------|--|---|

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| 24. FUNERAL DIRECTOR<br><b>Atkinson-Dickey Harrisonville, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>3/14/1961</b> | 26. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |
|---|--|---|

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF  
ITEM NO.

JUN 7 1961  
DEC 7 1961  
NOV 14 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Robert W. Cochran

Licensed Embalmer No. 4902

P. O. Address Hammond, La.

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.