

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034446

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 138 Primary Registration District No. 200 Registrar's No. 1319A

FILED SEP 24 1962

VS 300  
Rev. 4/59

10397

28320

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90530

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DATE AMENDED

11/9/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

18c Anaerobic streptococcal infection

DOCUMENT

BY AFFIDAVIT OF attending physician

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N. Carolina</b> COUNTY <b>Wake</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield, Missouri</b>		Length of stay in lb <b>93 days</b>	c. CITY OR TOWN <b>Raleigh</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>U. S. Medical Center</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>313 Grovemont St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ralph Hewitt Russell</b>			4. DATE OF DEATH Month Day Year <b>August 31 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/27/42</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>20</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>Fuquay Springs, N.C.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Paul Darden</b>		13b. MOTHER'S MAIDEN NAME <b>Naomi Mason</b>	14. NAME OF HUSBAND OR WIFE <b>Virginia Blackwell</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 3/20/60 to 9/25/60</b>		17. INFORMANT Address <b>MCFP Files, Springfield, Missouri</b>	
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) <b>Cerebral Anoxia</b>			<b>16 hours</b>
DUE TO (b) <b>Cardiac arrest and pulmonary edema</b>			<b>16 hours</b>
DUE TO (c) <b>Massive subcutaneous abscess of the back and severe systemic toxicity due to anaerobic streptococcal infection</b>			<b>12 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)			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 checked="" 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 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
21. I attended the deceased from <b>May 30, 1962</b> to <b>Aug. 31, 1962</b> and last saw <sup>her</sup> him alive on <b>August 31, 1962</b> Death occurred at <b>7:30 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr. Armond Moore</b> <b>Dr. Armond Moore, M.D.</b>		22b. ADDRESS <b>Springfield, Missouri</b>	22c. DATE SIGNED <b>8/31/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-1-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Raleigh, N.C.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR <b>W.B. Cantrell</b> <b>Republic, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>9-17-62</b>	26. REGISTRAR'S SIGNATURE <b>Effie G. Melton</b>

SEP 25 1962

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 William B. Cantrell

Licensed Embalmer No. 4858

P. O. Address Capelle, Mo

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.