

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

14334

1. PLACE OF DEATH

County Jackson
Township Kant
City Kansas City (No. 23rd)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 1879
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 5804 E. 11 St. 12 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr 4-1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
60 2 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) laying sod in yard
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paulding Ohio

10. NAME OF FATHER Orlando Addison Russell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Corinthia Corine Cochran

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Penn

14. INFORMANT (Address) Mrs Jennie Florence Cresson Albuquerque New Mexico

15. FILED 4 21 19 29 M. M. Corone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/19 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
12 (duration) yrs. mos. ds.
9.3
CONTRIBUTORY (SECONDARY) Chronic Intestinal
mythitis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
41 (Signed) Stanley M. Hall, M. D.
19 29 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Mt Washington April 22 1929

20. UNDERTAKER ADDRESS
Eglar Funeral Home 1800 Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS TO

237
22
22
22

