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.

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

41435

1. PLACE OF DEATH

County..... Registration District No. ..... File No. 12119

Township..... Primary Registration District No. ..... Registered No. .....

City..... (No. 5919 W. Pherson St. ..... Ward)

2. FULL NAME John August Russell

(a) Residence. No. 5919 McPherson St. 5 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Russell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 4 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	63	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sweden

PARENTS
10. NAME OF FATHER Zarus Russell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

14. INFORMANT G. E. Russell
(Address) 5919 W. Pherson

15. FILED ..... 19..... Max C. Starling REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1930

17. I HEREBY CERTIFY, That I attended deceased from 12/11/30, 19..., to 12/27/30, 19..., that I last saw him alive on 12/27/30, 19..., and that death occurred, on the date stated above, at 5 25 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arteria Sclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED, IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Sam L Bassett, M. D
12/28, 1930 (Address) 5427 Delmar

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mountain Grove Mo. DATE OF BURIAL Dec 29 1930

20. UNDERTAKER Philander Craig Washington ADDRESS 4468

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No.....,.... St., ...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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(ADDRESS)

15. FILED....., 19.....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... ....., M. D

, 19 (Address)

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.