

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20049

State File No. _____
Registrar's No. 4997

Registration District No. 79171940 Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St Louis, Mo
(b) City or town St Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
(c) City or town Jackson NR
(If outside city or town limits, write "RURAL")
(d) Street No. RR 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Ruby Gayle Russell. 240
8. (b) If veteran, 489-01-7281 (c) Social Security name war. No. S No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec. 6 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
24 6 0 hr. min.

9. Birthplace Jackson Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Shoe Factory

11. Industry or business _____
MOTHER FATHER { 12. Name B. B. Russell
13. Birthplace Jackson Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Carrie Shaner
15. Birthplace Jackson Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature D. B. Russell
(b) Address Jackson, Missouri.
17. (a) Removal (b) Date thereof 6-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fruitland, Mo.
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) JUN 10 1940 (b) _____
(Date and local registrar's signature) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1940 hour 9 45 minute P M.

21. I hereby certify that I attended the deceased from May 28, 1940, to June 6, 1940;
that I last saw her alive on June 6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Tuberculous Meningitis
Due to Bilat. Pulmonary Tuberculosis

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy Bilateral Tub. meningitis
Bilat. Pulmonary T.B.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature D. A. Anderson (M. D. or _____)
Address BARNES HOSPITAL Date signed 6-7-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

U. S. GOVERNMENT PRINTING OFFICE: 1931

Hopp

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Alvin G. Hopp*

Licensed Embalmer No. *2971*

P. O. Address.....

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 this body is not embalmed, above space should be left blank.