

FILED FEB 16 1942

Registration District No. 607

Primary Registration District No. 5802

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town New Madrid - Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No
In this community About 2 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME William Russell

8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife Bell Russell 6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased SEPT - 4 - 1891
(Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Mississippi Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name Jemethy Russell

13. Birthplace unk.
(City, town, or county) (State or foreign country)

14. Maiden name unk.

15. Birthplace unk.
(City, town, or county) (State or foreign country)

16. (a) Informant Bell Russell

(b) Address Libbourn Ryl.

17. (a) Burial (b) Date thereof Dec. 28 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dogwood

18. (a) Signature of funeral director Old hands and co

(b) Address New Madrid Mo.

19. (a) Jan. 14, 1942 (b) Alice Spiller
(Date received and registered) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 4 miles S. of New Madrid
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26
year 1941 hour 7:30 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on 12-25, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death unk. known

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 unk.

23. Signature G. N. Thomas (M. D. or other) _____

Address Libbourn Mo Date signed 12-27

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

72
0
0

RECEIVED

District Health Office No. 2,

District File Number 2-42-190

Date Filed 2-10-42

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

L. O. Hedgcock

Licensed Embalmer No.

3803

P. O. Address

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3012

Registration District No. 604

Primary Registration District No. 5802

Registrar's No. _____

1. PLACE OF DEATH

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Russell

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 4
(Month) (Day) (Year)

8. AGE: Years 50 Months 3 Days 2
(If less than one day _____ min)

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I first saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.
(Immediate cause of death _____) Duration _____

Due to Intestinal Stasis
no action

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify nature of injury)
(e) Means of injury _____

23. Signature W. H. Nelson (M. D. or other) _____

Address Delbourn _____ Date signed 9-5-12

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

SUPPLEMENTARY

MOTHER FATHER

[The page contains extremely faint and illegible text, likely a scan of a document with very low contrast or significant fading. The text is arranged in several paragraphs across the page, but no individual words or phrases can be discerned.]