

FILED FEB 18 1945

Registration District No. 349

Primary Registration District No. 4513

Registrar's No.

105
0
0

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Green Castle
(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 years, months or days) (Specify whether)

In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan

(c) City or town GREEN CASTLE
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME CLARINDA MAY RUSSELL

3. (b) If veteran, name war ✓

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 13
year 1943 hour 9:30 minute 15 A. M.

21. I hereby certify that I attended the deceased from NOV-15
1943 to JAN 13 1943

that I last saw her alive on JAN 12 1943
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

6. (a) 2 divorced 1 widowed

6. (b) Name of husband or wife John C Russell

6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased: May 4 1863
(Month) (Day) (Year)

Immediate cause of death: Cardiac Dropsy

Due to: Valvular Heart Disease

Due to: _____

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

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>8</u>	<u>9</u>	hr. min.

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

10. Usual occupation: Housewife

11. Industry or business _____

12. Name: Harvey R. Clifton

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

14. Maiden name: Margaret B. Hinkle

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

16. (a) Informant: Marie S. Speiser

(b) Address: Green Castle Mo.

17. (a) Burial (b) Date thereof: 1-17-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Green Castle

18. (a) Signature of funeral director: Marie S. Speiser

(b) Address: Green City, Mo.

19. (a) Feb 1-43 (b) Marie Davidson
(Date received local registrar) (Registrar's signature)

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)

(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: W. B. Schure (M.D. or other)

Address: Green City Mo. Date signed: 1-13-43

RECEIVED

District Health Officer No. 10

District File Number 2-43-352

Date Filed FEB 16 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Greenfield, 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, fact should be so stated above.