

No. 2  
2-43  
17-39  
X35697

Registration District No. 19449

Primary Registration District No. 1002

Registrar's No. 1415

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K. C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos. 20 days  
(Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

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

(d) Street No. County Home  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Earl Russell

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Sept. 5th 1907  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29  
year 1944 hour 3 minute 8P M.

21. I hereby certify that I attended the deceased from January 9 1944 to March 29 1944  
that I last saw him alive on March 29 1944  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>36</u>	<u>6</u>	<u>24</u>	hr. _____ min. _____

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

Immediate cause of death Tuberculosis of Spine

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 16  
(Include pregnancy within 3 months of death)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

12. Name Herbert Russell

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

14. Maiden name unknown

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy See above

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Record Clerk Gen'l Hosp.

(b) Address 24th Cherry

17. (a) Burial (b) Date thereof 3-31-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Tom A. Robinson

(b) Address City mortician

19. (a) 3-30-44 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

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)

(2) Means of injury \_\_\_\_\_

23. Signature W. E. Waters Dir. M.D.  
Address Gen'l Hosp Date signed 28 May 3-30-44

**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**