

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED SEP 7 1945 STANDARD CERTIFICATE OF DEATH**

State File No. 27303  
Registrar's No. 92

Registration District No. 107 Primary Registration District No. 3019

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

1. PLACE OF DEATH:  
(a) County: Dunklin  
(b) City or town: Kennett Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Fresnell - 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: Mo (b) County: Dunklin  
(c) City or town: Kennett Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No.: Route 1  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: LINDA FAY RUSSELL  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 8 day 28  
year 1945 hour 5 minute \_\_\_\_\_ P.M.

4. Sex: F 5. Color or race: W.  
6. (a) Single, widowed, married, divorced: 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Feb 11, 1945  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-18-1945 to 8-28-1945 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
6 18 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Gastroenteritis  
Due to: Malnutrition  
Due to: \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace: Kennett Mo  
(City, town, or county) (State or foreign country)  
10. Usual occupation: Man

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name: Pete Russell  
13. Birthplace: Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name: Mildred Duff  
15. Birthplace: Mississippi  
(City, town, or county) (State or foreign country)

16. (a) Informant: Pete Russell  
(b) Address: Kennett Mo  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-29-1945  
(Month) (Day) (Year)  
(c) Place: burial or cremation: Oak Ridge

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? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director: W.T. Emerson  
(b) Address: Harrisonville Mo  
19. (a) 8-29-45 (Date received local registrar) (b) Julia Blankenship (Registrar's signature)

23. Signature: Al Wilson (M. D. or other) Mo  
Address: Kennett Mo Date signed: 8-29-45

RECEIVED

District Health Office NO. 2

District File Number 945-295

Date Filed 9-4-45

**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.**