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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 17 1947

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5044

Primary Registration District No. 1002

Registrar's No. 592

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: Wheatley Provident Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 hours () (Specify whether

In this community 51 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED: 994

(a) State Kansas (b) County Wyandotte

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

(d) Street No. 1301 Armstrong ave 2 (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Myrtle Russell

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 3

5. Color or race negro

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

6. (b) Name of husband or wife Robert Russell

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased 7 (Month) 22 (Day) 1895 (Year)

8. AGE: Years 51 Months 6 Days 11 If less than one day hr. min.

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

10. Usual occupation House Work

11. Industry or business at Home

FATHER
12. Name Samuel C Walker
13. Birthplace (City, town, or county) Mississippi (State or foreign country)

MOTHER
14. Maiden name Lillie Palmer
15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Robert Russell

(b) Address 1301 Armstrong

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove K.C. Kans.

18. (a) Signature of funeral director Mrs. J. W. Jones

(b) Address 440 State ave K.C. Kans

19. (a) 2-8-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3 year 1947 hour 1 P.M. minute M.

21. I hereby certify that I attended the deceased from 2-1-47, 19, to 2-3-47, 19; that I last saw her alive on 2-3-47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy, Cerebral

Due to Compilation Acute Nephritis

Due to Obesity

Other conditions no (Include pregnancy within 3 months of death)

Major findings: Of operations no, no

Of autopsy no no

Duration

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) no no

(b) Date of occurrence no no

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? no (e) Means of injury no

23. Signature Henry B. Lyons (M. D. or other) M.D.

Address 1605 E. 18th Date signed 2/6/47

(Licensed Embalmer's Statement on Reverse Side)

Dr.
Lyons
18th & Vine
Lincoln Bldg.

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 Eugene English

Licensed Embalmer No. 4105

P. O. Address 1640 State Ave - K-C

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.