

S. No. 2
DM-5-43
v. 5-17-39
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36205

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **10125**

FILED NOV 14 1947 318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Lutheran Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 week**
(Specify whether life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **oao**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **3524 S. Broadway**
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Lawrence George Russ**

3. (b) If veteran, name war **no**

3. (c) Social Security No. _____

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 **August 10 1903**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

44	2	20	hr. min.
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9. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Nil**

11. Industry or business **Unemployed**

MOTHER FATHER

12. Name **William Russ**

13. Birthplace **Maxville Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Katherine Tiefenbrun**

15. Birthplace **Maxville Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Hazel Renneke**

(b) Address **3524 S. Broadway**

17. (a) **Burial** (b) Date thereof **Nov. 4, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**

(b) Address **7814 S. Broadway**

NOV 3 1947 (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **1**
year **1947** hour **3** minute **15** A. M.

21. I hereby certify that I attended the deceased from **October 26** 19**47** to **Oct 31** 19**47**
that I last saw him alive on **Oct 31** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Multiple lung abscesses Non-tubercular in origin**

Due to **Status Asthmaticus**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **11/4**

Duration **2 weeks**

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy **Multiple lung abscesses emphysema**

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 _____

Signature **Burhard Schmidt** (M. D. or other) **M.D.**

Address **600 W. Washington Ave** Date signed **11/1/47**

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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 *Lewis C. Hoffmeister*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.