

1. PLACE OF DEATH:

(a) County Newton  
 (b) City or town Fairview  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Modern Tourist Cabins  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 13 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON  
 (c) City or town FAIRVIEW  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. MODERN TOURIST CABINS  
 (If rural, give location)  
 (e) Citizen of foreign country? NO (Yes or No)  
 If yes, name country:

3. (a) PRINT FULL NAME SAMUEL JANE RUSSELL  
 3. (b) If veteran, name war: No.  
 3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 8  
 year 1947 hour 6 minute 15 M.

4. Sex FEMALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced WIDOWED  
 6. (b) Name of husband or wife DECEASED 6. (c) Age of husband or wife if alive — years  
 7. Birth date of deceased: MARCH 9 1864  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec - 7 - 1947 to Dec 8 - 1947  
 that I last saw him alive on Dec - 7 - 1947  
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
83 8 29 6 hr. 15 min.

Immediate cause of death: Respiratory Paralysis  
 Due to Cerebral Hemorrhage  
 Duration 24 hrs  
30 hrs

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation HOUSEWIFE  
 11. Industry or business  
 12. Name SAMUEL BELL  
 13. Birthplace (City, town, or county) (State or foreign country)  
 14. Maiden name SUBMIT STODDARD  
 15. Birthplace (City, town, or county) (State or foreign country) ILLINOIS

Major findings: g3 A  
 Of operations:  
 Of autopsy:  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Charlet. Cannon  
 (b) Address Haskell, Oklahoma  
 17. (a) Removal (b) Date thereof 12-9-1947  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Haskell Cemetery  
 18. (a) Signature of funeral director J. O. Snyder  
 (b) Address Haskell, Okla  
 19. (a) 12-14 1947 (b) Alpha Dyer  
 (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?  
 (Specify type of place)  
 While at work? (c) Means of injury 0  
 23. Signature D. S. McCall (M. D. or other)  
 Address Wheaton Mo. Date signed 12/8/47

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

MOTHER FATHER

RECEIVED  
District Health Officer No. *Newlin*  
District File Number *1247-233*  
Date Filed *12-22-47*

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.....

*Corley Thompson*

Licensed Embalmer No. *3259*

P. O. Address..... *Nesha 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.