

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 41801  
10865  
Registrar's No.

FILED DEC 23 1948  
700107

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether  
years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jefferson  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5105 Minnesota Memorial  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN RUSSELL  
3. (b) If veteran, name war none  
3. (c) Social Security No. none  
4. Sex Male  
5. Color or race W  
6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 10, 1866  
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Day 5  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation none  
11. Industry or business none  
12. Name John Russell  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Schaefer  
(b) Address 5105 Minnesota  
17. (a) Burial (b) Date thereof 12/16/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Imperial, Mo.  
18. (a) Signature of funeral director Franklin D. C.  
(b) Address 7420 Michigan  
19. (a) DEC 15 1948 (b) J. B. Jacobi  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 13th  
year 1948 hour 7 minute 55 P. M.  
21. I hereby certify that I attended the deceased from 12/2/48  
\_\_\_\_\_ 19 \_\_\_\_\_ to Dec. 13th 19 48  
that I last saw him alive on Dec. 13th 19 48  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of face c  
Metastases  
Due to Metastases  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) 53  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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) \_\_\_\_\_  
(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 \_\_\_\_\_  
23. Signature E. A. Carson, M.D. (M. D. or Other) 12/14/48  
Address 1515 Lafayette Date signed \_\_\_\_\_

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

MOTHER, FATHER

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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.....

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.**