

FILED JAN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 42431

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| BIRTH NO. | | REG. DIST. NO. <u>86</u> | | PRIMARY REG. DIST. NO. <u>4142</u> | | Registrar's No. | |
| 1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CRAWFORD</u> | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CUBA - BENTON</u> | | c. LENGTH OF STAY (in this place) <u>20 YRS.</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CUBA BENTON</u> | | d. STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>AUSTIN</u> c. (Last) <u>RUSSELL</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>12 30 1948</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>5-8-1900</u> | |
| 9. AGE (In years last birthday) <u>48</u> | | IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> | | IF UNDER 4 HRS. Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (State or foreign country) <u>STEELVILLE, MO.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13a. FATHER'S NAME <u>JAMES MILTON RUSSELL</u> | | 13b. MOTHER'S MAIDEN NAME <u>ETHEL MAE HANEY</u> | | 14. NAME OF HUSBAND OR WIFE <u>MILLIE GARGUS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>W-W-I</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Millie Russell</u> | | ADDRESS <u>no</u> | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. <u>NO</u> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchiectasis Due to War Service</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Endocarditis 5 26</u> <u>same</u> DUE TO (c) <u>Solar pneumonia secondary</u> <u>3 days</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Relieved 12/18 & present date this patient was treated by Vets. Hospital for above conditions.</u> | | | | | |
| 19a. DATE OF OPERATION <u>none</u> | | 19b. MAJOR FINDINGS OF OPERATION <u>none</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec. 20, 1948</u> , to <u>Dec. 30, 1948</u> , that I last saw the deceased alive on <u>Dec. 30, 1948</u> , and that death occurred at <u>8:25 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Joseph T. DeLeo M.D. D.C. L.</u> | | | | 23b. ADDRESS <u>Box 110 S. Cuba, Mo</u> | | 23c. DATE SIGNED <u>12-31-48</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>1-2-1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>KINDER CEMETERY</u> | | 24d. LOCATION (City, town, or county) (State) <u>CUBA Missouri</u> | |
| DATE REC'D BY LOCAL REG. <u>12-31-48</u> | | REGISTRAR'S SIGNATURE <u>Paul G. Shanklin</u> | | 372 25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert George</u> | | ADDRESS <u>Bourbon Mo</u> | |

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 1-4-49
District Health Officer No. 5,
District File Number 1493
Date Filed 1-10-49

JAN 20 1949

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

NORMAN - C - HOENER

Student Embalmer No. 445

working under my personal supervision.

Student

Norman C. Hoener
Student Embalmer

Signed

Elbert E. Long

Licensed Embalmer No.

3504

P. O. Address

Bourbon, 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.

State File No. Jet
Registrar's No. _____

Registration District No. 86

Primary Registration District No. 4149

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Cuba
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community 20 yrs. (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME James A. Russell

3. (b) If veteran, name was _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, married, divorced

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mar 8 1910
(Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days _____ (Less than one day)

hr. _____ min. _____

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

10. Usual occupation _____

MOTHER FATHER

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12-31-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Crawford

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

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

S-42431.