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THE DIVISION OF HEALTH OF MISSOURI
FILED MAY 11 1949 STANDARD CERTIFICATE OF DEATH

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State File No. 3889
Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 60	
b. CITY (If outside corporate limits, write RURAL and give town or town St. Louis		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1427a Cass Avenue		d. STREET ADDRESS (If rural, give location) 1427a Cass Avenue	
3. NAME OF DECEASED a. (First) Bell b. (Middle) c. (Last) Russell		4. DATE OF DEATH (Month) (Day) (Year) April 25, '49	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 12/15/1876
9. AGE (In years last birthday) 72 IF UNDER 1 YEAR Months 1 IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) Arkansas	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME West Willford		13b. MOTHER'S MAIDEN NAME Bell Unknown	
14. NAME OF HUSBAND OR WIFE Henry Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Herbert Russell	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 830	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 331X		22. I hereby certify that I attended the deceased from 1-15, 1949, to 4-25, 1949, that I last saw the deceased alive on 4-25, 1949, and that death occurred at 245 P.M., from the causes and on the date stated above.	
23a. SIGNATURE J.C. Sheppard, M.D.		23b. ADDRESS 2702a Franklin Avenue	
23c. DATE SIGNED 4-30-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Shipment	
24b. DATE April 30, 1949		24c. NAME OF CEMETERY OR CREMATORY Walnut Ridge, Arkansas	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Ave.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 30 1949 J.B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Ave.	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.