

No. 300
10.48

FILED SEP 22 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34750**

BIRTH NO. _____ REG. DIST. NO. **333** PRIMARY REG. DIST. NO. **3074** Registrar's No. **145**

1003
1

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

1. PLACE OF DEATH a. COUNTY SCOTT		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIKESTON		c. LENGTH OF STAY (in this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SIKESTON		1003 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 666 PARK		d. STREET ADDRESS (If rural, give location) 666 PARK	

3. NAME OF DECEASED (Type or Print) a. (First) ARCH b. (Middle) SOMERVILLE c. (Last) RUSSELL			4. DATE OF DEATH (Month) (Day) (Year) 9-17-1953		
5. SEX 0 MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9-19-1870	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months
				IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (City and State or Foreign Country) ARCADIA MO 0		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME GILES RUSSELL		13b. MOTHER'S MAIDEN NAME EMILY BERRYMAN		14. NAME OF HUSBAND OR WIFE CORINNA RUSSELL	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Max Arch Russell - Sikeston Mo	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-Sclerotic Heart Disease					
		ANTECEDENT CAUSES					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Hyper Zoster, ophthalmicus					
		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 checked="" type="checkbox"/>	
				4200C	

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) (Min.)			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 **5 Sept**, 1953 to **17 Sept**, 1953 that I last saw the deceased alive on **17 Sept**, 1953 and that death occurred at **12:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Leo G. Bruce, M.D.		23b. ADDRESS Stallard Bldg. Sikeston Mo		23c. DATE SIGNED 19 Sept 53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 9-19-1953		24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) (State) SIKESTON MO	
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DATE REC'D BY LOCAL REG. 9-21-53		REGISTRAR'S SIGNATURE Max Arch Russell		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Welch Funeral Home - Sikeston Mo	
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SEP 23 1953

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.

Student
Student Embalmer

Signed Raymond Grews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.