

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-013885
STATE FILE NUMBER 480

J. W. Klingner & Co.

FILED MAY 12 1958 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 480

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | c. CITY OR TOWN SPRINGFIELD | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mercy Hospital | | Length of stay in 1b 30 Yrs. | |
| d. STREET ADDRESS 2122 N. Campbell | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HETTIE Middle A. Last RUSSELL | | | 4. DATE OF DEATH Month May Day 5 Year 1958 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 Dec. 1892 |
| 9. AGE (In years last birthday) 65 | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (City and state or country) Arkansas |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME A. C. Weathers | 13b. MOTHER'S MAIDEN NAME Unknown |
| 14. NAME OF HUSBAND OR WIFE W. C. Russell | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, dates of service) No | 16. SOCIAL SECURITY NO. Unknown |
| 17. INFORMANT Hospital Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Arteriosclerotic-cardio vascular renal disease DUE TO (c) 442X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from 2-4-49 to 5-5-58 and last saw ^{her} him alive on 5-5-58 Death occurred at 10:00 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <i>A. M. K. Klingner M.D.</i> | | 22b. ADDRESS 1630 N. Jefferson Springfield, Mo. | |
| 22c. DATE SIGNED 5-5-58 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5-8-58 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greenlawn | | 23d. LOCATION (City, town, or county) (State) Springfield, Mo. | |
| 24. FUNERAL DIRECTOR J. W. Klingner & Co. | | ADDRESS Spgrfd. Mo. | |
| 25. DATE RECD. BY LOCAL REG. 5-7-58 | | 26. REGISTRAR'S SIGNATURE <i>Effie G. Melton</i> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *Max Rhodes*
407

Licensed Embalmer No.
P. O. Address *Spring*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.