

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-043027

FILED VS. NOV. 3 1959 333

Primary Registration District No. 3074

Registrar's No. 274

STATE FILE NUMBER

ENDED

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, give TOWNSHIP only) OR TOWN Sikeston		Length of stay in 1b	c. CITY OR TOWN Sikeston Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Community Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 207 Ruth Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLE Middle ANN Last RUSSELL			4. DATE OF DEATH Month 11 Day 15 Year 1959
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 5-5-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR WORKING	9. AGE (last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
11. BIRTHPLACE (City and state or country) CLARKSVILLE ARK		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Wm SWAN		13b. MOTHER'S MAIDEN NAME MARY RAINWATER	14. NAME OF HUSBAND OR WIFE JOHN HENRY RUSSELL
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 J H Russell - Sikeston Mo		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) Brain damage and pneumonitis DUE TO (b) Carbon monoxide intoxication DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Accidental inhalation of CO fumes	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. 11 12 59	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		20f. CITY, TOWN, OR LOCATION Sikeston	COUNTY Scott STATE Missouri
21. I attended the deceased from Nov. 12, 1959 to Nov. 15, 1959 and last saw her alive on Nov. 15, 1959 Death occurred at 11:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John P. Sargent, M.D.		22b. ADDRESS 707 Tanner Street Sikeston, Mo.	22c. DATE SIGNED Nov 17, 1959
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11-18-59	23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) SIKESTON MO
24. FUNERAL DIRECTOR Webb Funeral Home - Sikeston Mo		25. DATE RECD. BY LOCAL REG. 11-19-59	26. REGISTRAR'S SIGNATURE Mr. Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sebastian M

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.