

# MICHIGAN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023500

FILED VS JUN 21 1960

STATE FILE NUMBER

ENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 301

<b>1. PLACE OF DEATH</b> a. COUNTY <b>JACKSON</b> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>INDEPENDENCE</b> Length of stay in 1b <b>41 yrs.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> c. CITY OR TOWN <b>INDEPENDENCE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>905 WEST TRUMAN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lexington &amp; River, Indep.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>905 WEST TRUMAN</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>FRANK</b> Middle <b>A.</b> Last <b>RUSSELL</b>			<b>4. DATE OF DEATH</b> Month <b>JUNE</b> Day <b>16,</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Aug. 27, 1873</b>	<b>9. AGE (last birthday)</b> <b>86</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Minister-</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>KLDS Church -</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Near Tipton, Iowa</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>LESTER P. RUSSELL</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>SARAH SHUMWAY</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>GRACE A. RUSSELL</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>494-40-7048</b>		<b>17. INFORMANT</b> <b>Grace A. Russell, 905 W. Truman, Indep., Mo.</b> Address			

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO (b) <u>aortic stenosis + mitral regurgitation</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>  <u>1 year</u>
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 type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b> <b>STATE</b>	
<b>21. I attended the deceased from</b> <u>1931</u> <b>to</b> <u>5/31/60</u> <b>and last saw her</b> <u>5/16/60</u> <b>alive on</b> <b>Death occurred at</b> <u>10:30 a.m.</u> <b>m on the date stated above, and to the best of my knowledge, from the causes stated.</b>					

<b>22a. SIGNATURE</b> <u>Vance E. Lind, M.D.</u> (Degree or title)		<b>22b. ADDRESS</b> <u>Independence, Mo.</u>		<b>22c. DATE SIGNED</b> <u>6/16/60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE</b> <u>6-18-60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MOUND GROVE CEMETERY</u>	
<b>24. FUNERAL DIRECTOR</b> <u>GEO. C. CARSON &amp; SONS, INDEPENDENCE, MO.</u> ADDRESS		<b>25. DATE RECD. BY LOCAL REG.</b> <u>6-18-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

SEP 27 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Louis Quest

Licensed Embalmer No. 4096

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.