

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1961

6412-60-046317  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

UNDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>JACKSON</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		STATE <b>Missouri</b>		b. COUNTY <b>Jackson</b>	
Length of stay in 1b <b>48 YEARS</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3530 Wayne Avenue</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St Joseph's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>EDITH M.</b>		Middle <b>RUSSELL</b>		Last <b>December 19, 1960</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-2-1878</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (City and state or country) <b>COLORADO SPRINGS, COLO. U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>JOHN STEGGMAN</b>		13b. MOTHER'S MAIDEN NAME <b>EMMA JANE CHALONER</b>		14. NAME OF HUSBAND or wife <b>ANDREW JOHNSON RUSSELL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. KATHRYN MILLARD KANSAS CITY MO. 3530 WAYNE AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>HEPATOMEGALIA - PROBABLE PRIMARY CA.</b>						<b>6 MOS</b>	
DUE TO (b) <b>HEPATO-RENAL-CARDIAC FAILURE</b>						<b>5 DAYS</b>	
DUE TO (c) <b>PROBABLE TERMINAL MESENTERIC THROMBOSIS</b>						<b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>OLD H.C.V. DISEASE</b>						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 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 a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <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 <b>2-9-60</b> to <b>12-19-60</b> and last saw her/him alive on <b>12-19-60</b> Death occurred at <b>8:00 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>[Signature]</i>				22b. ADDRESS <i>[Address]</i>		22c. DATE SIGNED <b>12-20-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>DEC. 21, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>P.D.W. Newcomer's Sons 1331 BRUSH CREEK Kansas City, Missouri.</b>				25. DATE RECD. BY LOCAL REG. <b>12-21-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

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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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

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

Signed

*Vern Lawler*

Licensed Embalmer No. 4915

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