

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

7086-61-027296
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7086

AMENDED

FILED AUG 8 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> | | a. STATE <u>Mo</u> b. COUNTY <u>St Louis</u> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Lukes Hosp.</u> | | c. CITY OR TOWN <u>Afton</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>7839 Delmont St.</u> | |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|-------------------------------------|-------------------|---------------------|-------------------|---------------|------------------|--|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | | |
| First <u>Lillian</u> | Middle <u>May</u> | Last <u>Russell</u> | Month <u>July</u> | Day <u>30</u> | Year <u>1961</u> | |

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|----------------------|-------------------------------|---|-------------------------------------|----------------------------------|--|---|--|
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 21 1912</u> | 9. AGE (last birthday) <u>48</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 11. BIRTHPLACE (City and state or country) <u>Atlanta Gas.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
|----------------------|-------------------------------|---|-------------------------------------|----------------------------------|--|---|--|

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| 13a. FATHER'S NAME <u>Frank McCoy</u> | 13b. MOTHER'S MAIDEN NAME <u>Bessie Thompson</u> | 14. NAME OF HUSBAND OR WIFE <u>James A. Russell</u> |
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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) <u>No.</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>James A. Russell</u> | Address <u>7839 Delmont</u> |
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| 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) <u>Chronic myelocytic leukemia</u> | | <u>1 year</u> |
| DUE TO (b) _____ | | |
| DUE TO (c) _____ | | |

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| 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 |
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| 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.) |
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| 20c. TIME OF INJURY Hour <u>8 p.m.</u> Month, Day, Year _____ |
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|--|--|------------------------------|--------|-------|
| 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 Sept. 3, 1960 to July 30, 1961 and last saw her live on July 30, 1961
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Joseph A. Hefley M.D.</u> | (Degree or title) | 22b. ADDRESS <u>3720 Washington Blvd. St. Louis 8 Mo.</u> | 22c. DATE SIGNED <u>7/31/61</u> |
|--|-------------------|--|------------------------------------|

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|---|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Aug. 2 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Bur. PK.</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Watt Bros.</u> | ADDRESS <u>6409 Brown Ave.</u> | 25. DATE RECD. BY LOCAL REG. <u>JUL 31 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u> |
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DATE AMENDED
INSTEAD OF
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

DOCUMENT
MEDICAL CERTIFICATION

Dr. Edwards 1018

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 Harvey Kalle

Licensed Embalmer No. 4596

P. O. Address St Louis, 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.