

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

505162-020938
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED MAY 31 1962		1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 42 years		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5919 Mc Pherson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 5919 Mc Pherson Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grant Middle Edwin Last Russell			4. DATE OF DEATH Month May Day 18 Year 1962		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-21-1890	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Timber Co.		11. BIRTHPLACE (City and state or country) Chicago, Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME John August Russell		13b. MOTHER'S MAIDEN NAME Anna Lindholm	
14. NAME OF HUSBAND OR WIFE Vava Terrill Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Mrs. Grant E. Russell, 5919 Mc Pherson, 12	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. - DUE TO (b) Right cerebral hemorrhage. DUE TO (c) Hypertensive C.V. Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) sev. years. Primary Anemia					INTERVAL BETWEEN ONSET AND DEATH 9 days sev. yrs.
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.) 443X	
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 St. Louis		20g. COUNTY Delmar		20h. STATE Mo	
21. I attended the deceased from 1931 to MAY 18 '62 and last saw him alive on MAY 15, 1962 Death occurred at 8:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>R. B. Barritt M.D.</i>			22b. ADDRESS 5427 Delmar		22c. DATE SIGNED MAY 18 '62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-21-62		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
23d. LOCATION (City, town, or county) St. Louis County		24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, 6175 Delmar Blvd.		25. DATE RECD. BY LOCAL REG. MAY 18 1962	
26. REGISTRAR'S SIGNATURE <i>Lead Smith M.D.</i>					

VS 300
Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(In office from 1:00 to 5:00 P.M. Friday)

Dr. Robert Bassett
5427 Delmar Blvd.
Phone: FO 7-0392

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 Joseph E. McCallister

Licensed Embalmer No. 2480

P. O. Address 6175 Delmar

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.