

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030465

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7191 STATE FILE NUMBER

FILED JUL 25 1963

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>25 yrs.</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST. LOUIS</u>		c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer Phillips Hosp.</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2856 Union Blvd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nellie L Hayden (Lottie) Russell</u>			4. DATE OF DEATH Month Day Year <u>July 9, 1963</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11/7/07</u>	9. AGE (last birthday) <u>55</u>	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) <u>Storekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Delicatessen</u>		11. BIRTHPLACE (City and state or country) <u>Chaffee, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>W. R. Hayden</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Craig</u>		14. NAME OF HUSBAND OR WIFE <u>Louis Russell</u>			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. <u>[REDACTED]</u>		17. INFORMANT Address <u>Katherine Robinson 1519A St. Clair East St. Louis</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage;</u> DUE TO (b) <u>Cirrhosis of the Liver; apparently</u> DUE TO (c) <u>suffered in fall in home on 7-7-63</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>accident</u> PART III. If deceased was female was there a pregnancy in last 90 days. <u>904021</u> <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>		20c. TIME OF INJURY? Hour a.m. p.m. Month, Day, Year <u>7-7-63</u>		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.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Louis Mo</u>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>5:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>						22b. ADDRESS <u>1300 Clark Ave.</u>			22c. DATE SIGNED <u>7-10-63</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/12/1963</u>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		23d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>		24. FUNERAL DIRECTOR <u>John A. Ogonoski</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 11 1963</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1

2 206

3

4 1

5 3

6

7 0

8 1

9 7

10

11 OTD

12 47-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

XXXXXXXXXX

XXXXXXXXXX

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 _____ *Not Embalmed* Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed *John A. Gonosh*

Licensed Embalmer No. *3398*

P. O. Address _____

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.