SEP 27 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24003

1. PLACE OF DEATH
County: Dent
Township: Lemons
City: ..... (No. ..... St. ..... Ward)

Registration District No. 934
Primary Registration District No. 3368

File No. .....
Registered No. 20

2. FULL NAME: Albert J. Ross

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—Every item of information should be carefully [illegible] PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be [illegible] of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF: Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR): December 6 1926

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Thomson Co Mo

PARENTS

10. NAME OF FATHER: Albert K Ross
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Texas Co Mo
12. MAIDEN NAME OF MOTHER: Gaddon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Thomson

14. INFORMANT: W. L. Jones
(Address) Salem Mo

15. Aug 31 1927 J. B. Gordon
Filed ..... 19 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 31, 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1927, to Aug 18 1927, that I last saw him alive on Aug 18 1927, and that death occurred, on the date stated above, at ..... a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dysentery
15 Yrs
(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Out home
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical
(Signed) J. B. Gordon M. D
, 19 ..... (Address) Bunker Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Winnesville Mo
DATE OF BURIAL: 19

20. UNDERTAKER: W. L. Jones
ADDRESS: Salem Mo

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Dent — Registration District No. 954 — File No.
Township Sinkin — Primary Registration District No. 5368 — Registered No. 20
City (No. St. Ward)

2. FULL NAME Albert Jr Ross
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT W. L. Jones
(Address) Bunker Mo

15. Aug 31, 1927 J. B. Gordon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 31 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)

(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Willoville Mo	Sept 2, 1927
20. UNDERTAKER	ADDRESS
W. L. Jones	Bunker Mo

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B. ... supplied. AGE should be stated EXACTLY. ... PHYSICIAN ... state
CAUSE OF DEATH in plain terms, so that it may be ... classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR ... COMPLETE AS PRESCRIBED BY LAW

24003