

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

Do not use this space.

11472

1. PLACE OF DEATH

County.....
Township.....
City..... *St. Louis*

Registration District No. *791*
Primary Registration District No. *1003*
City Hospital **1*

File No.....
Registered No. *3243*
St. ... Ward)

2. FULL NAME

John Ross
(a) Residence, No. *7310 Pennsylvania St.* Ward. *1*

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* | 4. COLOR OR RACE *White* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widower*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug-17-1853*

7. AGE: YEARS *74* | MONTHS *7* | DAYS *4* | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer) *Stationary*
(c) Name of employer

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

10. NAME OF FATHER *John Ross*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ireland*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Ireland*
(STATE OR COUNTRY)

14. INFORMANT *Teal St. Clair*
(Address) *730 Pennsylvania*

15. FILED *May C. Taskiff* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** *Nov-20-19*

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 *12:30 P.M.* *21066*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shock - Injuries (Septicæmia) + ulcerated knee struck by Auto in City of St. Louis
CONTRIBUTORY (SECONDARY) *Accident*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAPTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *[Signature]* M. D. *2/11/28* (Address) *Converse*

*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 *Bloomington Ind.* DATE OF BURIAL *3/25 1928*

20. UNDERTAKER *Southern U & L Co* ADDRESS *7315 S. Bidway*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERMANENT RECORD

**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 Registration District No. 291 File No.
 Township Primary Registration District No. 1003 Registered No. 3243
 City St. Louis (No.) St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>W</u>
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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.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

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 Mrs. John Sinclair
 (Address) 7216 Pennsylvania

15. FILED 10 19 May Stark
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 21 1928

17. I HEREBY CERTIFY, That I attended deceased from
 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:

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

19

20. UNDERTAKER ADDRESS

Southern

PERMANENT RECORD

STADIING INK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-11402