

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

Do not use this space.

19357

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... St. Louis Primary Registration District No. 1003
 City..... St. Louis (No. City Hospital #2) Registered No. 5797
 Street..... Ward.....

2. FULL NAME

Major Ross
 (a) Residence, No. 422 1/2 Finney St., 11 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mamie Ross
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15, 1872
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 | 8 | 11 |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer
 (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) Miss.

PARENTS

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

14. INFORMANT Wm. H. Woodard
 (Address) City Hospital #2

15. FILED 29 1935 Max C. Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 26, 1928
 17. I HEREBY CERTIFY That I attended deceased from 2/29, 1928, to 5/26, 1928
 that I last saw him alive on 5/25, 1928, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
inlet. J. O. B.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED not known
 IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? no DATE OF
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) W. H. Hards, M. D.
 (Address) City Hosp. #2

*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 Greenwood Cem DATE OF BURIAL 5/30 1928

20. UNDERTAKER W. S. Wade ADDRESS 4202 Finney

WRITE FULLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

