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

Do not use this space.
14413

File No. 1933

WRITE PLAINLY, 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.

1. PLACE OF DEATH
County Nelson Registration District No.
Township Raymond Primary Registration District No. Registered No.
City R.E. Mo. (No. Ward Hospital #2 St. Ward)

2. FULL NAME Elia Ross (SHAW)
(a) Residence. No. 6211 & 30 St., 14 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 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): Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 18 64

7. AGE: 67 YEARS; 0 MONTHS; 6 DAYS; If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(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): Iowa

PARENTS
10. NAME OF FATHER: Roscoe, Ross
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ky. Kentucky
12. MAIDEN NAME OF MOTHER: Rose Ross
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Iowa

14. INFORMANT: Record Clerk City #2
(Address)

15. FILED 4/25, 1931 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 24 1931

17. I HEREBY CERTIFY, That I attended deceased from 4/13, 1931, to 4/24, 1931, that I last saw h. alive on 4/14, 1931, and that death occurred, on the date stated above, at 7 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Lobar
15D
79A (duration) yrs. mos. 6 ds.
CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) yrs. mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home & Hosp.
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. Shuler, M. D.
4/25, 1931 (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.
Mon. 10 o'clock

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Highland
DATE OF BURIAL: April 27, 1931

20. UNDERTAKER: Adkins Bros
ADDRESS: 2000 E. 12th

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County .....

Township .....

City ..... (No. ..... Ward. .....)

2. FULL NAME .....

(a) Residence. No. ..... Street. ..... (If inside city limits, give ward.)

(Usual place of abode) ..... Inside city limits? .....

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. WHETHER EVER MARRIED (WIDOWED, OR DIVORCED)

5a. IF MARRIED, WIDOWED, OR DIVORCED (give full name) HUSBAND OF (OR) WIFE OF

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

7. AGE		
YEARS	MONTHS	DAYS

If less than 1 day, ... hrs. ..... min.

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

9. 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 .....

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 ..... (Address) .....

15. FILED ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(a) ..... (duration) .....

(b) ..... (duration) .....

CONTRIBUTORY (SECONDARY) .....

(duration) .....

18. WHERE DID DEATH CONTRIBUTE

IF NOT AT PLACE OF DEATH

DID AN OFFICIAL INVESTIGATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ..... M. D.

19. ..... (Address) .....

*Give the disease or injury which initiated the morbid process resulting in death, or in the absence of such disease or injury, the immediate cause of death. Do not use the terms of organ failure, shock, or heart failure unless they are the ultimate causes of death, and in all cases give the underlying cause of death.

20. UNDERTAKER .....

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

	ADDRESS	DATE OF BURIAL
19		

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