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

16933

PLACE OF DEATH
County Wayne Registration District No. 892 File No.
Township Williams Primary Registration District No. 4341 Registered No.
City Williamsville (No. St. Ward)

FULL NAME Wonetta Louise Ross

(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

SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word):

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) April 28 1931

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
			3½	

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

BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Williamsville Mo.

10. NAME OF FATHER Sherman Lu Ross

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Wayne Co. Mo.

12. MAIDEN NAME OF MOTHER Ida May Grumall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Wayne Co. Mo.

INFORMANT Sherman Ross
(Address) Williamsville Mo.

FILED April 28 1931 Mrs. Hallie McGhee
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 28 1931

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:
Premature birth at 7th mo. of gestation
Baby lived 3½ hrs.
1.59 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1.59
(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) D A Myers, M. D.
April 28 1931 (Address) Greenville 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Halladay Cem. DATE OF BURIAL: April 29 1931

20. UNDERTAKER: None ADDRESS

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

MARGIN RESERVED FOR BINDING

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (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. d

PERSONAL AND STATISTICAL PARTICULARS

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

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 .....
(Address)

15.
FILED....., 19..... .....
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..
that I last saw h..... alive on....., 19....., and
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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

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
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, sta
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, (
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS