

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.

SEP 19 1940  
AUG 19 1940  
90

Registration District No. \_\_\_\_\_

Primary Registration District No. **3002**

Registrar's No. **120**

1. PLACE OF DEATH:

(a) County Andrain  
(b) City or town Mexico  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Andrain Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 **PRONOUNCED DEAD**  
(Specify whether)  
In this community 12 YEARS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrain  
(c) City or town Mexico R#1  
(If outside city or town limits, write "RURAL")  
(d) Street No. Trolley Heights  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME PAUL ROSS JR  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 491-05-6987

20. DATE OF DEATH: Month Sept day 12  
year 1940 hour 5 minute 5 P.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife ELEANOR FRELAND 6. (c) Age of husband or wife if alive 25 years  
7. Birth date of deceased March 14, 1911  
(Month) (Day) (Year)

Immediate cause of death Coroner Case  
Due to Being struck by train while crossing track  
Due to \_\_\_\_\_

8. AGE: Years 28 Months 5 Days 28  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

9. Birthplace Stadmon Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Brick Plant Worker

11. Industry or business A.P. REEN Co.

MOTHER FATHER  
12. Name W. C. Ross  
13. Birthplace Callaway Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name JENNA Shaffer  
15. Birthplace Callaway Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W.C. Ross  
(b) Address Mexico, Mo.

17. (a) Buried (b) Date thereof 9/14/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Chas Amador  
(b) Address Mexico, Mo.

19. (a) Sept 14 1940 (b) Blanche Neely  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence Sept 12 1940  
(c) Where did injury occur? Mexico Andrain Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Wabash Ry. - A.P. Reen Br Plant  
While at work? Mo (Specify type of place) (e) Means of injury HIT BY TRAIN  
23. Signature W.C. Ross (M.D. or other) Coroner  
Address Andrain Andrain Date signed 9/14 1940

110 mi  
95

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Arvo Amundson*

Licensed Embalmer No. *3569*

P. O. Address *Minneapolis*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

27837  
State File No. 120

Registration District No. 26 Primary Registration District No. 3002 Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County. Andrew  
(b) City or town. Mexico  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.  
In this community. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Paul Ross  
(b) If veteran, name war. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
(b) Name of husband or wife. (c) Age of husband, or wife, if alive. years

7. Birth date of deceased. (Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day min.  
28 5 28

9. Birthplace. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name.  
13. Birthplace. (City, town, or county) (State or foreign country)  
14. Maiden name.  
15. Birthplace. (City, town, or county) (State or foreign country)

16. (a) Informant. (b) Address.

17. (a) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)  
(c) Place: burial or cremation.

18. (a) Signature of funeral director. (b) Address.

19. (a) Sept 17/40 (b) Blanche Keely  
(c) (If received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. (b) County.  
(c) City or town. (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. years.

20. DATE OF DEATH. Month Sept day 12 year 1940 hour. minute M.

21. I hereby certify that I attended the deceased from 19. to 19. that last saw h. alive on 19. and that death occurred on the date and hour stated above.

Immediate cause of death. Coroner's Case  
Being struck by train while crossing tracks  
Due to Pedestrian  
Other conditions. (Include pregnancy within 3 months of death)  
Major findings: Of operations. Of autopsy.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify). acc  
(b) Date of occurrence. Sept 12 1940  
(c) Where did injury occur? Mexico (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Weber, Ry. a. P. Power Plant. (Specify type of place) (e) Means of injury.

23. Signature. W. Marshall (M. D. or other) Coroner  
Address. Andrew Date signed.

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **27837**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **26**

Primary Registration District No. **3002**

Registrar's No. **120**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Anderson**  
(b) City or town **Paris**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME **Paul Ross**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **m** 5. Color of race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife, if alive **1911** years

7. Birth date of deceased **mar 14**  
(Month) (Day) (Year)

8. AGE: Years **29** ~~28~~ Months **5** Days **28** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) **Sept 14/40** (b) **Blanche Neal**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Sept** day **12**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL