

FILED SEP 24 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29191**

Registration District No. **607**

Primary Registration District No. **4361**

Registrar's No. **42**

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:**  
 (a) County New Madrid  
 (b) City or town Portageville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
X X X  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution X  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** John Ross 2nd  
**3. (b) If veteran,** X  
**3. (c) Social Security** X  
 name No.

**4. Sex** Male **5. Color or race** Col. **6. (a) Single, widowed, married,** Married  
**6. (b) Name of husband or wife** Natie Ross **6. (c) Age of husband or wife if** 72  
 alive years  
**7. Birth date of deceased** March 14, 1862  
(Month) (Day) (Year)

**8. AGE:** Years 78 Months 5 Days 10 If less than one day X  
 hr. min.

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

**10. Usual occupation** Farming

**11. Industry or business** Farming

**MOTHER FATHER**  
**12. Name** Tom Ross  
**13. Birthplace** Miss. (City, town, or county) (State or foreign country)  
**14. Maiden name** Leticia Jones  
**15. Birthplace** Miss. (City, town, or county) (State or foreign country)

**16. (a) Informant's own signature** Tom Ross  
**(b) Address** Portageville, Mo.

**17. (a) (b) Date thereof** 4-4-40  
(Burial, cremation or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Portageville

**18. (a) Signature of funeral director** L. L. ...  
**(b) Address** Liberum, Mo.

**19. (a) (b)** ...  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo (b) County New Madrid  
 (c) City or town Portageville  
(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 2  
 year 1940 hour 2 minute ... P. A. M.  
**21. I hereby certify that I attended the deceased from** Aug. 28, 1940, to Aug. 2, 1940;  
 that I last saw him alive on Sept. 2, 40, 19...;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
 Due to Arteriosclerosis  
 Due to ...  
 Other conditions extremly old age  
(Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings: ...  
 Of operations ...  
 Of autopsy No  
 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) ...  
 (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?  
530 (Specify type of place)  
 While at work? ... (e) Means of injury ...  
**28. Signature** d. d. ... (M. D. or other) !  
 Address Portageville, Mo. Date signed Sept 3, 40

RECEIVED  
District Health Office  
District File Number 940-  
Date Filed 9/37

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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

State File No. 29191

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 607

Primary Registration District No. 4361

Registrar's No.

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Partagerville  
(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)

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.

3. (a) PRINT FULL NAME John Ross

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

4. Sex m 5. Color or race col 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 15 If less than one year hr. 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 (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) 9-3-1940 (b) Mary W. Cook  
(Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 2 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ 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 \_\_\_\_\_

Duration  
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) \_\_\_\_\_  
(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 A. A. Reeder (M. D. or other) \_\_\_\_\_  
Address Partagerville, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

