FILED SEP 19 1941

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

28415
Do not use this space.

1. PLACE OF DEATH
(a) County Harrison
(b) Township Trail Creek
(c) City Mt. Moriah
Registration District No. 331
Primary Registration District No. 5475
Registered No. 4
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Hargaret Louise Ross
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Ross

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4/19/1848.

7. AGE: Years 93 | Months 3 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Warsaw
(STATE OR COUNTRY) Missouri

FATHER
13. NAME Calvin Lloyd
14. BIRTHPLACE (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Chloe Ann Dillon
16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Virginia

17. INFORMANT Esther Chambers
(ADDRESS) Bethany Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt. Moriah Mo DATE 8/6/1941, 19

19. FUNERAL DIRECTOR John M Chambers
(ADDRESS) Mt Moriah Mo

20. FILED 8/6 19 41 Mrs C J Sellers
Local Registrar

MEDICAL CERTIFICATE OF DEATH 3-PM

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8/4/1941, 19

22. I HEREBY CERTIFY, That I attended deceased from Aug 4th, 1941, to Aug 4, 1941
I last saw h. alive on Aug 2nd, 1941. Death is said to have occurred on the date stated above, at 6 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	8/4/41

43A

Other contributory causes of importance:
Arteriosclerosis

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) C J Sellers M. D.
(Address) Mt Moriah Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

STATEMENT BY LICENSED EMBALMER

I, John M Chambers, Licensed Embalmer No. 2109

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed John M Chambers

Licensed Embalmer No. 2109

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

. No. 2B
—8-21-41
PI-X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28415

Registration District No. 339 Primary Registration District No. 5475 Registrar's No. 4

1. PLACE OF DEATH:

(a) County: Harrison

(b) City or town: Mt Moriah
(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 ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Harrison

(c) City or town: Mt. Moriah
(If outside city or town limits, write "RURAL")

(d) Street No. —
(If rural, give location)

(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME: Margaret L. Reas

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Wid.

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: April (Month) 19 (Day) 1848 (Year)

8. AGE: Years | Months | Days | If less than one day: 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) (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) 8-6-1941 (Date received local registrar) (b) Mrs C. J. Sellers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day ..... year ..... 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 ..... Duration

Due to .....

Due to .....

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)

(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? (Specify type of place)

While at work? ..... (e) Means of injury

23. Signature ..... (M. D. or other)

Address ..... Date signed

SUPPLEMENTARY