

FILLED NOV 17 1941

Registration District No. **347**

Primary Registration District No. **5485**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Henry**
(b) City or town **Rural Bogard Twp**
(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 **75 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Henry**
(c) City or town **Rural**
(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? **0** years

3. (a) PRINT FULL NAME **James David Ross**

8. (b) If veteran name was _____ 8. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Rosa Ross** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct 3 1861**
(Month) (Day) (Year)

8. AGE: Years **80** Months **0** Days **14** If less than one day _____ hr. _____ min.

9. Birthplace **Pikes Co., Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **William Ross**

13. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Hagler**

15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ma Bessie Dun**
(b) Address **Wich. Mo.**

17. (a) **Burial** (b) Date thereof **10-21-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Robert Arnold**

(b) Address **Craighton Mo.**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **18**
year **1941** hour **12** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **July 24**
19**41** to **October 17**, 19**41**
that I last saw him alive on **October 17**, 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Acute hemorrhage from stomach

Due to _____
Due to _____
Other conditions **Carcinoma of stomach 4 months**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations **H&E**
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 **Dr. R. G. Hall** (M. D. or other) **MD**
Address **Clinton Mo** Date signed **10/21/41**

RECEIVED

District Health Officer No. 7,

District File Number 11-41-1878

Date Filed 11-13-41

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 Herbert Arnold

Licensed Embalmer No. 3621

P. O. Address Craighton, Mo.

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.

Registration District No. 347

Primary Registration District No. 5485

Registrar's No.

1. PLACE OF DEATH: Henry Rural

(a) County Henry

(b) City or town Rural
(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)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME James D Ross

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her 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 w

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

7. Birth date of deceased: Oct 3 1891
(Month) (Day) (Year)

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years 80 Months - Days - (If less than one day, in min.)

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

10. Usual occupation _____

11. Industry or business _____

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)

Major findings: Of operations _____

Of autopsy _____

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

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 _____

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 _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) Dr. J. R. Hamilton (Registrar's signature)

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

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

MOTHER FATHER

SUPPLEMENTARY

