S. No. 2
M—5-42
. 5-17-39
PI X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 5 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 29554

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2582

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5714 Anderson
(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 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 5714 Anderson 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Martha Washington Ross

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Charles H. Ross

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

7. Birth date of deceased September 24 1859 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
83	0	4	hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Washington H. Skelton
13. Birthplace Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sara E. Wright
15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Mr. George Tillman Ross

(b) Address 5714 Anderson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-1942 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address Kansas City, Mo.

19. (a) 9-29-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 28th. year 1942 hour 7 minute 40 A. M.

21. I hereby certify that I attended the deceased from Aug. 24th, 1942, to Sept. 27, 1942, that I last saw her alive on Sept. 27, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic myocardial degeneration	10 yrs.
Due to Essential Hypertension	2 yrs.
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? (c) Means of injury

23. Signature J. J. Cocsik (M. D. or other) D.O.

Address 5962 St. John Date signed 9/28/42

(Licensed Embalmer's Statement on Reverse Side)

Dr. J.J.Pocsik
5902 St. John Ch 4062

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 Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. C. 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, fact should be so stated above.