

FILED MAY 13 1943

Registration District No. 374

Primary Registration District No. 6273-4547

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Worth  
(b) City or town Grant City, Mo.  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Worth  
(c) City or town Allendale, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME William Riley Ross

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

4. Sex male 5. Color or Race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Mary Elizabeth Ross 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased 6 - 2 - 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 | 10 | 7 | ..... hr. .... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name William Ross  
13. Birthplace unknown Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Patricia Coffman  
15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Ross  
(b) Address Allendale, Mo.  
17. (a) Burial (b) Date thereof 4-12-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Fletcher Cemetery

18. (a) Signature of funeral director Arch A Duffler  
(b) Address Grant City, Mo.  
19. (a) April 20 1942 (b) Arden Scadden  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 9  
year 1943 hour 5 minute 30 A.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.....  
myocardial

Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations.....  
Of autopsy.....  
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 Arch A Duffler (M.D. or other) Mo  
Address Grant City, Mo. Date signed 4-11-43

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

MOTHER FATHER

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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

*Arch C. Dinglee*

Licensed Embalmer No. *3252*

P. O. Address. *Grant City, 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.**