

U. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X36671

FILED JAN 10 1944  
Registration District No. 377

Primary Registration District No. 3063

96  
2  
3

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

1. PLACE OF DEATH:  
 (a) County St. Louis.  
 (b) City or town Clayton.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Villa Duchesne. 5  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 Years.  
(Specify whether

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County St. Louis 96  
 (c) City or town Villa Duchesne, Clayton. 2  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Conway and Spoede, Clayton. 5  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mother Ann Rachel Gross.  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month January day 6th.  
 year 1944 hour 8. minute 20 P. M.

4. Sex F. 5. Color or race W.  
 6. (a) Single, widowed, married, divorced S.  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased January 15, 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 1943, to Jan 1944, that I last saw her alive on Jan 2 1944 and that death occurred on the date and hour stated above.  
 Immediate cause of death Carcinoma of the ovaries

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>11</u>	<u>21</u>	_____ hr. _____ min.

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

9. Birthplace Las Vegas, New Mexico 3  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Librarian.

Major findings: Carcinoma of ovaries with metastasis  
 Of operations \_\_\_\_\_  
 Of autopsy 194  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
 12. Name Jacob Gross.  
 13. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name Caroline Linton.  
 15. Birthplace Don't Know 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mother Tracy  
 (b) Address Conway & Spoede Rd  
 17. (a) Burial (b) Date thereof 1-8-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery.

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? \_\_\_\_\_

18. (a) Signature of funeral director Arthur J. Donnelly  
 (b) Address 3840 Kendall Blvd.  
 19. (a) JAN 8 - 1944 (b) E. J. McKernan, Jr.  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature Joe L. Green (M. D. or other) \_\_\_\_\_  
 Address 16651 E. Knight Date signed 1-7-44

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF HEALTH SERVICES

2-5-7  
6651  
St. James  
Crematorium

**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.