

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4404

FILED NOV 14 1944  
799

Registration District No. 799

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
805 Beacon  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 10 years  
years, months or days

3. (a) PRINT FULL NAME Clarence Otho Ross

3. (b) If veteran, name war No 3. (c) Social Security No. 495-03-5790

4. Sex M O 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Velma Etta Ross 6. (c) Age of husband or wife if alive Dec. years  
7. Birth date of deceased Dec. 20, 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
55 10 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

MOTHER FATHER

11. Industry or business Ford Motor Company  
12. Name Harry R Ross  
13. Birthplace Princeton, Ill  
(City, town, or county) (State or foreign country)  
14. Maiden name Delia Hay Shaw  
15. Birthplace Coshocton, Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Coroners Record  
(b) Address Court house

17. (a) Cremation (b) Date thereof Nov. 1, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director John P Sheil  
(b) Address K.C., Mo.

19. (a) 11-1-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 42  
(c) City or town Kansas City, Mo. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 805 Beacon 2  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive or \_\_\_\_\_ Deputy Coroner 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death. Acute Carbon Monoxide

Due to Intoxication

Due to Gas Heater

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy See Above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 123  
(b) Date of occurrence 10/29/44  
(c) Where did injury occur? Kansas City Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? No (Specify type of place) (e) Means of injury Carbon Monoxide

23. Signature A. E. Userer (M.D. or other) MD  
Address 23 McCoy Date signed 10/31/44

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

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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.....

*John P. Smith*

Licensed Embalmer No. *3625*

P. O. Address *W. 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.**