

FILED JAN 11 1945

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **338**

1. PLACE OF DEATH

(a) County **Adair**
(b) City or town **Pikeville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home Health**
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution **20 days** (Specify whether
In this community **55 yrs** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Macon**
(c) City or town **Rural**
(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

Nettie Mable Ross

3. (b) If veteran, name war **✓**

3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, divorced, **married**

6. (b) Name of husband or wife **Wes H. Ross** 6. (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Dec 7 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **15** Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation **House Keeper**

11. Industry or business _____

12. Name **Samuel T. Hudson**

13. Birthplace **Mo** (City, town, or county) (State or foreign country)

14. Maiden name **Mary Carson**

15. Birthplace **Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Wes H. Ross**

(b) Address **Tallata Mo**

17. (a) **Rural** (b) Date thereof **Dec 20 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **La Platte Mo**

18. (a) Signature of funeral director **La Platte Mo**

(b) Address **La Platte Mo**

19. (a) **12-29-44** (b) **Mr. J. H. Wagner**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **22**
year **1944** hour **10** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **November 21**, 19**44** to **Dec 22**, 19**44**
that I last saw her alive on **Dec 22**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal hemorrhage** Duration **2 days**

Due to **Possible perforation lower bowel** 4 days

Due to **Banister disease (splenomegaly)** 8 mos

Other conditions (Include pregnancy within 3 months of death) **27 11**

Major findings: Of operations **Spleen removed Nov 27**

Of autopsy **None**

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) (e) Means of injury **CS**

23. Signature **George E. Ginn** (M. D. or other) **MD**

Address **Pikeville, Missouri** Date signed **12-23-44**

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

MOTHER FATHER

