

FILED JAN 25 1945

State File No.

513

Registration District No. 318

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis Children's
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. 22 days
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5057 Westminster
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Florence Griffin Ross

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

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 12 10 44
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 7 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Walter W. Ross
 13. Birthplace Columbia Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Gladney
 15. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant W. Bernard
 (b) Address 504 S. Kingshighway

17. (a) Burial (b) Date thereof 1-18-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Calvary - bur

18. (a) Signature of funeral director Walter B. Ford
 (b) Address 6110 Delaney Ave

19. (a) JAN 17 1945 J. F. Bredeek
 (Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 17
 year 45 hour 4 minute 30 AM.

21. I hereby certify that I attended the deceased from 12-26-1944 to 1-17-1945
 that I last saw h. e. r. alive on 1-17-1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis - Influenza
Meningococcal

Due to Congenital

Due to _____
 Other conditions (include pregnancy within 3 months of death) 151

Major findings: Of operations _____
 Of autopsy Florence Meningitis

Duration _____
 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? _____

While at work? _____ (Specify type of place) (e) Months of injury 0

23. Signature Gilbert B. Forbes (M. D. or other) _____
 Address 500 So. Kingshighway Date signed _____

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

MOTHER FATHER

Embalmer Separate Cert. filed

JAN 17 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.