

V. S. No. 2  
 00M-3-43  
 Rev. 5-17-39  
 X37823

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 26467  
 Registrar's No. 293

14  
 1  
 2

25313

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

FILED SEP 6 1946

Registration District No. \_\_\_\_\_ Primary Registration District No. 3008

1. PLACE OF DEATH:  
 (a) County Galloway  
 (b) City or town Fulton  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
State Hospital no 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 yr. 10 mo 19 days  
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Pemiscot 14  
 (c) City or town Cassherville (If outside city or town limits, write "RURAL") 2  
 (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 Ross  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex male 2 5. Color or race white 6. (a) Single, widowed, married, divorced divorced  
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased May 5 1891  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month August day 27 year 1946 hour 2 minute 40 P. M.  
 21. I hereby certify that I attended the deceased from Aug 1 1946 to Aug 27 1946  
 that I last saw him alive on August 27 1946  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>3</u>	<u>22</u>	hr. _____ min. _____

Immediate cause of death Cerebral Hemorrhage  
 Due to 7th vertebrae + arterial sclerosis  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER  
 11. Industry or business \_\_\_\_\_  
 12. Name Jim Ross  
 13. Birthplace Jayce 1 (City, town, or county) (State or foreign country)  
 14. Maiden name Cora Lee Blackburn  
 15. Birthplace Jayce 1 (City, town, or county) (State or foreign country)  
 16. (a) Informant County Court  
 (b) Address Cassherville Mo  
 17. (a) Removal (b) Date thereof Aug 30 1946  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Louis, Mo  
 18. (a) Signature of funeral director Wm G. Manpin  
 (b) Address 712 Court St. Fulton, Mo  
 19. (a) Aug 30 1946 (b) Josee Morsudoff  
 (Date received local registrar) (Registrar's signature)

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 0  
 23. Signature Forrest Thomas (M. D. or other)  
 Address Fulton Mo Date signed 9/1/46

RECEIVED

District Health Officer No. 9,

District File Number

Date Filed

~~9-16-58~~  
~~9-1-46~~

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.....

*Harold M. Douglas*

Registered Apprentice No. *410*

working under my personal supervision.

Signed *Glen G. Mangin*

Licensed Embalmer No. *2725*

P. O. Address *Fulton, 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.