

S. No. 2  
M-8-13  
7-5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26623

FILED AUG 1 1947

Registration District No. 579

Primary Registration District No. 4552

Registrar's No.

1. PLACE OF DEATH:

(a) County WRIGHT  
(b) City or town MANSEFIELD  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 50 yrs  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County WRIGHT  
(c) City or town MANSEFIELD  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? N.O. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME OLIVE MAY ROSS

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife CHARLES S. ROSS 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased APRIL 20 1865  
(Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace DES MOINES IOWA  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business \_\_\_\_\_

12. Name CHRISTOPHER BORDERS

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

14. Maiden name AMANDA SLY

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

16. (a) Informant BERTIE BAGGETT

(b) Address BAXTER SPRINGS KANS

17. (a) BURIAL (b) Date thereof 7/26/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OKONOGA-MO.

18. (a) Signature of funeral director J.A. Steffe

(b) Address MANSEFIELD MO.

19. (a) 7/25/47 (b) Keith Staud-Depl  
(Date received local registrar) (Registrator's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22  
year 1947 hour 5 minute 45 P.M.

21. I hereby certify that I attended the deceased from July 20, 1947, to July 22, 1947  
that I last saw him alive on July 22, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thromb Duration 1 day

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: GA  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) While at work? \_\_\_\_\_ (e) Means of injury 0

23. Signature J. A. Faison (M. D. or other) \_\_\_\_\_

Address Mansefield Mo Date signed 7-25-47

(Licensed Embalmer's Statement on Reverse Side)

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

4  
50

MOTHER FATHER

✓

RECEIVED

District Health Officer No. 6,

District File Number 747-805

Date Filed 11/28/1947

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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 F.A. Stiffe

Licensed Embalmer No. 3221

P. O. Address Manfield 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.