

S. No. 2  
M-5-43  
5-17-39  
X36671

FILED NOV 22 1947

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 201 Primary Registration District No. 5735

1. PLACE OF DEATH:  
(a) County Macon  
(b) City or town Atlanta (Rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution None  
In this community all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Macon  
(c) City or town Atlanta (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 Jessie Collins Ross  
3. (b) If veteran name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 31st.  
year 1947 hour 3:30 minute 2 - M.  
21. I hereby certify that I attended the deceased from Oct 27, 1947, to Oct 31st, 1947.  
That I last saw her alive on Oct 30th, 1947  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife J. Tom Ross  
6. (c) Age of husband or wife if alive Deceased years  
7. Birth date of deceased: Dec 22 1960  
(Month) (Day) (Year)

Immediate cause of death: Acute Myocarditis - Cerebral Hemorrhage - Hypertension  
Due to Arteriosclerosis -  
Other conditions Slight Obesity  
(Include pregnancy within 3 months of death)

8. AGE: Years 86 Months 10 Days 10  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

10. Usual occupation Retired  
11. Industry or business \_\_\_\_\_  
12. Name Americus B. Collins  
13. Birthplace Tenn (City, town, or county) (State or foreign country)  
14. Maiden name Hannah Jane Ellison  
15. Birthplace Monroe, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Ruby Carnahan  
(b) Address Atlanta Mo  
17. (a) Burial (b) Date thereof 11-2-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Labor Cemetery

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 \_\_\_\_\_  
23. Signature Ruby Carnahan (M. D. or other) MO  
Address Macon, Mo Date signed 11/1/47

18. (a) Signature of funeral director H. B. Gillingham  
(b) Address Atlanta Mo  
19. (a) Nov 14 1947 (b) Mrs O. D. Gillingham  
(Date received local registrar) (Registrar's signature)

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

RECEIVED  
District Health Officer No. 10  
District File Number 11-47-1599  
Date Filed NOV-20-1947

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..... *H. W. [Signature]*

Licensed Embalmer No..... 1750

P. O. Address..... Atlanta 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.**