FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28523

FILED SEP 7 1948

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 1965

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Manchester (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Pine Crest Home, Div. #2 4 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Illinois (b) County: Randolph
(c) City or town: Sparta (If outside city or town limits, write "RURAL")
(d) Street No.: 701 E. Main St. (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

999
11
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0

3. (a) PRINT FULL NAME: Mary Ross
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife: Will Ross
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: April (Month) 14 (Day) 1858 (Year)

8. AGE: Years 90 | Months 4 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace: Patterson (City, town, or county) N. Jerseey (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: Own Home

MOTHER FATHER
12. Name: James Kearns
13. Birthplace: Ireland (City, town, or county) (State or foreign country)
14. Maiden name: Rachael Carson
15. Birthplace: N. Jersey (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. George A. Rust
(b) Address: Sparta, Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 8-19-48 (Month) (Day) (Year)
(c) Place: burial or cremation: Sparta, Ill.
18. (a) Signature of funeral director: Albert H. Hoppe
(b) Address: 4700 Washington Blvd.
19. (a) 8-19-48 (Date received local registrar) (b) Cecil A. E. Sharp, M.D. (B.H.) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 18 year: 1948 hour: 2 minute: 30 P.M.

21. I hereby certify that I attended the deceased from Feb 1, 1948, to Aug 18, 1948; that I last saw h. alive on Aug 18, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis
Due to: senility 931
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy:

Duration

PHYSICIAN
Underline the cause of 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: A. L. Merklin M.D. (M. D.)
Address: 3507 Bronx Date signed: 8-19-48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

A. L. Merklin, M.D.

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

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 Frank J. Shyland.

Licensed Embalmer No. 2645

P. O. Address St Lorraine

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.