

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31396**  
Registrar's No. **8186**

FILED OCT 1 1948

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town **St. Louis**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Homer G Phillips Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8 days** (Specify whether  
In this community **22 months** (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME **Jo Ann Ross**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **single (✓)**

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

7. Birth date of deceased **October 28, 1946**  
(Month) (Day) (Year)

8. AGE: Years **1** Months **10** Days **18** If less than one day hr. min.

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

10. Usual occupation -----

11. Industry or business -----

12. Name **Joe Ross**

13. Birthplace **Starksville Miss.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Smith**

15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Anna Ross**

(b) Address **3154 r. Evans Avenue**

17. (a) **Burial** (b) Date thereof **9-18-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oaki Dale**

18. (a) Signature of funeral director **Allen Dales**

(b) Address **3506 Franklin Avenue**

19. (a) **SEP 20 1948** (b) **J. J. Brack**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **San**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **3154 Evans**  
**21** (If rural, give location)  
(e) Citizen of foreign country? ----- (Yes or No)  
If yes, name country -----

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **16**  
year **1948** hour **3** minute **50 a.m.**

21. I hereby certify that I attended the deceased from **Sept. 8**, 1948, to **Sept. 16**, 1948,  
that I last saw h. **er** alive on **Sept. 16**, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death **LUNGS: Hemorrhage, Congestion - Not J.B.**  
**SPLEEN AND LIVER: Congestion Undet.**

Due to -----  
Due to -----

Other conditions **Brain: Puncture wound,**  
(Include pregnancy within 3 months of death)  
**surgical.**

Major findings: **Recent-Patchial Hemorrhage**  
Of operations -----  
Of autopsy **Yes**

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 **Allen E. North** (M. D. or other)  
Address **2601 N Whittier** Date signed **9/17/48**

**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. 4441

P. O. Address. 2829 Washington

**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.**