

FILED MAY 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14559

BIRTH NO. _____		REG. DIST. NO. <u>331</u>		PRIMARY REG. DIST. NO. <u>4484</u>		Registrar's No. <u>6</u>		
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Commerce</u>		c. LENGTH OF STAY (in this place) <u>8 yrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Commerce</u>		d. STREET ADDRESS (If rural, give location) <u>No street address</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>No street address</u>				d. STREET ADDRESS (If rural, give location) <u>No street address</u>				
3. NAME OF DECEASED a. (First) <u>Rachel</u>			b. (Middle) <u>(None)</u>		c. (Last) <u>Ross</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-20-1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 4, 1912</u>		9. AGE (In years last birthday) <u>36</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Crockett Co., Tenn. /</u>		12. COUNTRY OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Orange Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Mag Conley</u>		14. NAME OF HUSBAND OR WIFE <u>Malchia Ross, Dec'd.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None Known</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Georgetta Kates, R#2, Alamo, Tenn.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Toxemia</u> ANTECEDENT CAUSES <u>Intestinal Obstruction</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 week (Heart)</u> <u>4 wks (Heart)</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP, (COUNTY) (STATE) <u>Charleston, Missouri</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>SUPPLEMENTARY INFORMATION REQUESTED</u>				
22. I hereby certify that I attended the deceased from <u>4-29-1949</u> , to _____, 19____, that I last saw the deceased alive on <u>4-29-1949</u> , and that death occurred at <u>7:10A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>W. A. Sengal M.D.</u>					23b. ADDRESS <u>Charleston, Missouri</u>		23c. DATE SIGNED <u>5-2-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-2-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>May-6-49</u>		REGISTRAR'S SIGNATURE <u>Miss Addie Harney</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Joe Nunnlee Charleston, Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Office No. 2,

District File Number 549-565

Date Filed 5-9-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Joe R. Nunnlee

Licensed Embalmer No. 4413

P. O. Address Charleston, W.

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.