

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6670**

BIRTH NO. 11556-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1296

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, state before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. LENGTH OF STAY (In this place) <b>2' 15"</b>		d. STREET ADDRESS (If rural, give location) <b>11 - 4163 MAFFITT</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS MATERNITY HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) / a. (First) <b>INFANT</b> b. (Middle) <b>MALE</b> c. (Last) <b>ROSS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>2- 4-50</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER MARRIED</b>	
8. DATE OF BIRTH <b>FEBRUARY 4, 1950</b>		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Days	
11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>			

13a. FATHER'S NAME <b>GEORGE ROSS</b>		13b. MOTHER'S MAIDEN NAME <b>LORENE ANDERSON</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME <b>77bx</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>PREMATURITY (PRE-VIABLE)</b>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)			
		DUE TO (c)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <b>77bx</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9:05 pm 4 Feb 1950, to 11:20 pm 4 Feb 1950, that I last saw the deceased alive on 4 Feb, 19 50, and that death occurred at 11:20 m., from the causes and on the date stated above.

23a. SIGNATURE <b>Bertram S. Roth MD</b>		23b. ADDRESS <b>St. Louis Maternity Hosp.</b>		23c. DATE SIGNED <b>6 Feb 50</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>FEB 9 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>	
				24d. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>FEB 9 1950</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland Searles - 4104 Manchester</b>		ADDRESS	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 \_\_\_\_\_

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed .....

Licensed Embalmer No. ....

P. O. Address .....

**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.**