

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33140

State File No.

FILED OCT 16 1951

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 132

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Washington</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>327 W. 6th St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Joseph</u>	b. (Middle) <u>Powell</u>	c. (Last) <u>Ross Jr.</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>10</u> <u>1</u> <u>1951</u>

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 22, 1902</u>	9. AGE (In years last birthday) <u>49</u>	IF UNDER 1 YEAR <u>3</u> Months <u>10</u> Days	IF UNDER 24 HRS. <u>0</u> Hours <u>0</u> Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	---------------------------------------	-------------------------------------------	------------------------------------------------	-----------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Repair</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Radio</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
-----------------------------------------------------------------------------------------------------------------	------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------

13a. FATHER'S NAME <u>Albert Powell Ross</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Rosemeyer</u>	14. NAME OF HUSBAND OR WIFE <u>Edith Ross</u>	<u>Washington, Mo</u>
----------------------------------------------	-------------------------------------------------	-----------------------------------------------	-----------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edith Ross</u>	ADDRESS <u>Washington, Mo</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute cardiac decompensation</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocarditis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>nephritis</u>			

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>Washington (Franklin) Mo</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? _____
-------------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------------

22. I hereby certify that I attended the deceased from Jan, 1957, to Oct 1, 1951, that I last saw the deceased alive on Oct 1, 1951, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. P. Test</u>	(Degree or title) _____	23b. ADDRESS <u>Washington, Mo</u>	23c. DATE SIGNED <u>10/2/51</u>
----------------------------------	-------------------------	------------------------------------	---------------------------------

24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 4, 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Washington, Missouri</u>
------------------------------------------------------------	------------------------------	----------------------------------------------------------------	---------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>Oct 2, 1951</u>	REGISTRAR'S SIGNATURE <u>F. L. Hedemann</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard W. Little</u>	ADDRESS <u>Washington, Mo</u>
---------------------------------------------	---------------------------------------------	-----------------------------------------------------------	-------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

69
0

2. 1001

File No. _____
DISTRICT HEALTH OFFICE No. 4

OCT 9 1951

RECEIVED

NOV 21 1951

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

Jerome F. Swaboda

Licensed Embalmer No. 4507

P. O. Address 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.