

FILED DEC 31 1951

STANDARD CERTIFICATE OF DEATH

State File No. 41435

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 72

1. PLACE OF DEATH
 a. COUNTY HOWELL
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS
 c. LENGTH OF STAY (in this place) 5 days
 d. FULL NAME OF HOSPITAL OR INSTITUTION CHRISTIA HOGAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE Missouri b. COUNTY OREGON
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN AITON 0750
 d. STREET ADDRESS (If rural, give location) _____

3. NAME OF DECEASED (Type or Print)
 a. (First) JULIA b. (Middle) THORNTON c. (Last) ROSS
 4. DATE OF DEATH (Month) (Day) (Year) 12-10-51

5. SEX F 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
 8. DATE OF BIRTH 12-1-1976 9. AGE (in years last birthday) Months Days Hours Min. 75 0 9 _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
 10b. KIND OF BUSINESS OR INDUSTRY _____
 11. BIRTHPLACE (State or foreign country) Ware county, Mo.
 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME ALBERT HILL 13b. MOTHER'S MAIDEN NAME NANCY (unknown) ROSS 14. NAME OF HUSBAND OR WIFE Thomas J. ROSS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____
 16. SOCIAL SECURITY NO. _____
 17. INFORMANT'S SIGNATURE OR NAME Christia Hogan Hospital ADDRESS _____

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, asthma, etc. It means the disease, injury, or complication which caused death.
 MEDICAL CERTIFICATION
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis
 ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) arteriosclerosis
 DUE TO (c) _____
 II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.
 INTERVAL BETWEEN ONSET AND DEATH 2 yrs
70 yrs

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION 4221
 20. AUTOPSY? YES NO

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) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 12-5, 1951, to 12-10, 1951, that I last saw the deceased alive on 12-10, 1951, and that death occurred at 8:50 a. m., from the causes and on the date stated above.

23a. SIGNATURE Ch. Callahan M.D. (Degree or title) 23b. ADDRESS West Plains, Mo. 23c. DATE SIGNED 12/18/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 12-11-51 24c. NAME OF CEMETERY OR CREMATORY Barley Chapel cemetery 24d. LOCATION (City, town, or county) (State) OREGON

DATE REC'D BY LOCAL REG. 12-20-51 REGISTRAR'S SIGNATURE Beatrice Cook 379 25. FUNERAL DIRECTOR'S SIGNATURE John D. Clay ADDRESS Aiton

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

COMMISSION OF HEALTH OF MD.
District No. 5 - Springfield
DEC 26 1951
Dist. File 1227-3126
Date Filed 12-28-51

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

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *John Q. Clary*

Licensed Embalmer No. *4475*

P. O. Address *Box 398 Altan Md*

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.