No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7225

BIRTH NO. _____ REG. DIST. NO. 4 PRIMARY REG. DIST. NO. 4014 Registrar's No. 15

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

1. PLACE OF DEATH
a. COUNTY: ATCHISON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): FAIRFAX, MO
c. LENGTH OF STAY (in this place): 11 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FAIRFAX COM. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: ATCHISON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL-POLK TWSP 0030
d. STREET ADDRESS (If rural, give location): NONE 0

3. NAME OF DECEASED (Type or Print)
a. (First): NELLIE
b. (Middle): JANE
c. (Last): ROSS

4. DATE OF DEATH (Month) (Day) (Year): 2 - 29 - 52

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 8-2-1886
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months 6, Days 27 — IF UNDER 24 HRS.: Hours, Min.

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): PARKVILLE, MO 0
12. CITIZEN OF WHAT COUNTRY?: AM.

13a. FATHER'S NAME: WM. A. CARPENTER
13b. MOTHER'S MAIDEN NAME: SARAH HARMON
14. NAME OF HUSBAND OR WIFE: GEORGE ROSS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: EDDIE ROSS — ADDRESS: WATSON, MO

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) 331 X

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 ☐ 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) m.
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* Feb. 16, 1952, *to* Feb. 29, 1952 *that I last saw the deceased alive on* Feb. 29, 1952, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. A. Reuter M.D.
23b. ADDRESS: Rockport, Mo.
23c. DATE SIGNED: 3/4/52

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 3-3-1952
24c. NAME OF CEMETERY OR CREMATORY: HIGHCREEK, CEM.
24d. LOCATION (City, town, or county) (State): WATSON MO

DATE REC'D BY LOCAL REG.: Mar 12, 1952
REGISTRAR'S SIGNATURE: Marvin H. Schaller 443
25. FUNERAL DIRECTOR'S SIGNATURE: Bartholomew Mortuary — ADDRESS: Rock Port Mo

(Licensed Embalmer's Statement on Reverse Side)

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 [illegible]

Licensed Embalmer No. 3173

P. O. Address Rock Port, Mo.

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.