

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36790**
9740
Registrar's No.

FILED NOV 13 1952

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY —		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) 5 hrs. 30 min.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Evangelical Deaconess		d. STREET ADDRESS (If rural, give location) 315 Main	
3. NAME OF DECEASED (Type or Print) a. (First) — b. (Middle) — c. (Last) Ross			4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1952
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH Sept. 30, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 5 IF UNDER 1 YEAR Months 3 IF UNDER 24 HRS. Hours 30 Min. 0
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Eugene Ross		13b. MOTHER'S MAIDEN NAME Patricia Ann Peniston	
14. NAME OF HUSBAND OR WIFE —		17. INFORMANT'S SIGNATURE OR NAME Mr. T. Ross ADDRESS 315 Main Savanna, Ill.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
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) Spontaneity - Not readable. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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)	
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? 776X	
22. I hereby certify that I attended the deceased from Sept. 30, 1952 , to Sept. 30, 1952 , that I last saw the deceased alive on Sept. 30, 1952 and that death occurred at 8⁰⁰ A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Lois Kelly M.D. (Degree or title)		23b. ADDRESS 4952 Maryland	
23c. DATE SIGNED 9/30/52			
24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE 10-31-52	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. OCT 23 1952	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service ADDRESS 4104 Manchester Ave.	

(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.....

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.