

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35901

FILED NOV 1 - 1954

State File No. _____
Registrar's No. 9531

BIRTH NO. 74383-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Comer G. Phillips</u>		d. STREET ADDRESS (If rural, give location) <u>21 2807 Easton</u>	
3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) <u>Ross</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9 23 54</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	8. DATE OF BIRTH <u>9-21-54</u>
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>0</u>
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME <u>Norma Jean Ross</u>	14. NAME OF HUSBAND OR WIFE
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 ADDRESS <u>Father W. S. ... 2601 N. Whittier</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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Premature birth, neonatal death</u> ANTECEDENT CAUSES Morbid 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>7735</u>	
22. I hereby certify that I attended the deceased from <u>9-21</u> , 19 <u>54</u> to <u>9-23</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-23</u> , 19 <u>54</u> , and that death occurred at <u>4:30 pm.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William N. Simbler M.D.</u>		23b. ADDRESS <u>2601 N. Whittier</u>	23c. DATE SIGNED <u>9-29-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>10-30-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
DATE REC'D BY LOCAL REG. <u>OCT 20 1954</u>	REGISTRAR'S SIGNATURE <u>Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland-Aker Mortuary Service</u> <u>4104 Manchester Ave.</u> <u>St. Louis 10, Mo.</u>	

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

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.