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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7024

State File No. ....

FILED MAR 7 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 381 PRIMARY REG. DIST. NO. 4516 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY OR TOWN <u>Milan</u>	c. LENGTH OF STAY (in this place) <u>1 day</u>	c. CITY OR TOWN <u>Humphreys</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SEM Hospital</u>		f. STREET ADDRESS (If rural, give location) <u>1050</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>EUNICE</u>	b. (Middle) <u>OPHELIA</u>	c. (Last) <u>ROSS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>2-21-55</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10-1-1891</u>	9. AGE (In years last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>New Boston Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Willard Barford</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John Ross</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <u>Floyd Ross</u>	ADDRESS <u>Humphreys Mo</u>
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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>Coronary Occlusion</u>		<u>Instant</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Toxemia</u>		<u>2 weeks</u>
DUE TO (c) <u>Anal Fistula</u>		<u>3 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Patent head Chronic Myocarditis</u>		<u>Year</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from July, 1950, to Feb, 1955, that I last saw the deceased alive on Feb 21, 1955, and that death occurred at 7:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Alton Walker Eitel M.D.</u>	23b. ADDRESS <u>Galt Mo</u>	23c. DATE SIGNED <u>2/23/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-24-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Humphreys Mo</u>
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DATE REC'D BY LOCAL REG. <u>2-28-1955</u>	REGISTRAR'S SIGNATURE <u>Mrs. H. B. Harris</u>	330	25. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Payne</u>	ADDRESS <u>Galt Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed..... *PK Payne Jr*

Licensed Embalmer No. *340*

P. O. Address..... *Galt*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.