

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21847**

FILED JUL 18 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 613

1. PLACE OF DEATH  
a. COUNTY GREENE

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE MISSOURI b. COUNTY GREENE

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD c. LENGTH OF STAY (In this place) 3 DAYS

c. CITY OR TOWN SPRINGFIELD d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION: CITY HOSPITAL

e. STREET ADDRESS (If rural, give location) 2336 N. RAMSEY

3. NAME OF DECEASED  
a. (First) JAMES b. (Middle) J. c. (Last) ROSS

4. DATE OF DEATH (Month) (Day) (Year) JULY 12, 1955

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER

8. DATE OF BIRTH 2 MARCH 1865

9. AGE (In years last birthday) (Months) (Days) (Hours) (Mins.) 90

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groceryman

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (City and State or Foreign Country) POLK CO., MISSOURI

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel Ross

13b. MOTHER'S MAIDEN NAME Hedger

14. NAME OF HUSBAND OR WIFE DECEASED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. No

17. INFORMANT'S SIGNATURE OR NAME ADDRESS HOSPITAL RECORDS

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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Congestive Heart Failure  
ANTECEDENT CAUSES Coronary Occlusion  
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. H2O1

INTERVAL BETWEEN ONSET AND DEATH  
2 week  
2 week

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)

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 July 9, 1955, to July 11, 1955, that I last saw the deceased alive on July 11, 1955 and that death occurred at 10:35 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Earl R. Russell, M.D.

23b. ADDRESS Springfield, Mo.

23c. DATE SIGNED 7-13-55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-14-55

24c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery

24d. LOCATION (City, town, or county) (State) Springfield, Mo.

DATE REC'D BY LOCAL REG. 7-14-55

REGISTRAR'S SIGNATURE Edith Williamson

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.W. Chugner & Co. Springfield, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 *Glen D. Williams*.....

Licensed Embalmer No. *465*

P. O. Address *Springfield*

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.