

FILED SEP 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29499

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 839

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Greene | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE Illinois b. COUNTY Macon | |
| b. CITY (If outside corporate limits, write RURAL and give town) Springfield | | c. CITY OR TOWN Decatur | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) 42 hours | | e. STREET ADDRESS (If rural, give location) 315 South Calhoun | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St John's Hospital | | 81208 | |
| 3. NAME OF DECEASED (Type or Print) a. (First) DAVID | | b. (Middle) WILEY | |
| c. (Last) ROSS | | 4. DATE OF DEATH (Month) (Day) (Year) September 21 1955 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married | 8. DATE OF BIRTH July 3, 1935 |
| 9. AGE (In years last birthday) 20 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.F.C. Marines | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Marines | 11. BIRTHPLACE (City and State or Foreign Country) Peoria, Illinois | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Albert L. Ross | |
| 13b. MOTHER'S MAIDEN NAME Esther Wiley | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Present member | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT'S SIGNATURE OR NAME Henry G. Ross, Chicago, Illinois | | ADDRESS | |
| 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. 9.19.55 | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary thrombus ANTECEDENT CAUSES DUE TO (b) Fractured pelvis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Ruptured spleen + Bladder II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 8164 26 | |
| INTERVAL BETWEEN ONSET AND DEATH 2 hrs 48 hrs 48 hrs | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Ruptured spleen + Bladder | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 416 | |
| 21c. (CITY, TOWN, OR TOWNSHIP) Eg Lebanon (COUNTY) Laclede, Mo (STATE) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 19, 1955 | |
| 21e. HOW DID INJURY OCCUR? Car accident (2-CAR) | | 21f. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from 9.19.55 , 1955, to 9.21.55 , 1955, that I last saw the deceased alive on Sept. 21 , 1955, and that death occurred at 1:40A m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE William F. Johnson, M.D. (Degree or title) | | 23b. ADDRESS 211 Professional Bldg. Springfield, Missouri | |
| 23c. DATE SIGNED 9.21.55 | | 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | |
| 24b. DATE Sept 22, 1955 | | 24c. NAME OF CEMETERY OR CREMATORY Mansfield Cemetery | |
| 24d. LOCATION (City, town, or county) Decatur, Illinois (State) | | DATE REC'D BY LOCAL REG. 9-22-55 | |
| REGISTRAR'S SIGNATURE Edith Williams | | 25. FUNERAL DIRECTOR'S SIGNATURE Alma Schmeyer, Springfield, Mo ADDRESS | |

(Licensed Embalmer's Statement on Reverse Side)

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

300
46

OCT 3 1955

SEP 26 1958

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 *Robert E. Muhlman*

Licensed Embalmer No...*491*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.