

FILED JAN 31 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **3473**BIRTH NO. _____ REG. DIST. NO. **322** PRIMARY REG. DIST. NO. **3071** Registrar's No. **10**

1. PLACE OF DEATH a. COUNTY Saline			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Saline		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		c. LENGTH OF STAY (In this place) 3 mo	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		
d. FULL NAME OF HOSPITAL OR INSTITUTION Emma St. Slater Mo			d. STREET ADDRESS (If rural, give location) Hotel Saline		
3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Ebner c. (Last) Bross			4. DATE OF DEATH (Month) (Day) (Year) Jan 23 1956		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 28, 1886 69		9. AGE (In years last birthday) IF UNDER 1 YEAR Months 3 Days 25 IF UNDER 18 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and State or Foreign Country) Hallsville, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Larry Bross		13b. MOTHER'S MAIDEN NAME Leona Bross	14. NAME OF HUSBAND OR WIFE Leona Fausser		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes	16. SOCIAL SECURITY NO. 710-05-6072	17. INFORMANT'S SIGNATURE OR NAME Deceased left information			
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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 2 mo
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Infectious Hepatitis				3 mo
	DUE TO (c) Arterio Sclerosis				3 yr
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 442x				
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10-15 , 19 55 , to 1-18 , 19 56 , that I last saw the deceased alive on 1-18 , 19 56 , and that death occurred at 2:00 m., from the causes and on the date stated above.					
23a. SIGNATURE W. G. Lockwood M.D.		(Degree or title)		23b. ADDRESS Slater, Mo.	23c. DATE SIGNED 1-23-56
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Jan 24 1956	24c. NAME OF CEMETERY OR CREMATORY Slater City Cemetery	24d. LOCATION (City, town, or county) (State) Slater, Mo.		
DATE REC'D BY LOCAL REG. 1-28-56	REGISTRAR'S SIGNATURE Ms. Earl C. Metz	25. FUNERAL DIRECTOR'S SIGNATURE G. S. Jones	ADDRESS R. Willmington		

(Licensed Embalmer's Statement of Burial See 1)

FEB 6 1958

FEB 1 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
Student Embalmer

Signed Walter J. Haine, Jr.

Licensed Embalmer No. 2557

P. O. Address Slater, N.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.