

FILED SEP 4 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26610

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 781

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Aurora Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION OSTEOPATHIC HOSPITAL Length of stay in 1b 1 day		d. STREET (If outside, give location) ADDRESS 224 Jefferson, St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHYL C. ROSS First Middle Last			4. DATE OF DEATH Aug. 26, 1956 Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1902
9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY Doctor
11. BIRTHPLACE (City and state or country) Watson, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joel T. Cooper		14. MOTHER'S MAIDEN NAME Callie Allman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Callie Cooper Aurora Mo Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure			INTERVAL BETWEEN ONSET AND DEATH 29 HRS
Conditions, if any, which gave rise to 'above cause (a), stating the underlying cause last. DUE TO (b) medullary paralysis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) Basal skull fracture			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 46			
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in an elevator that crashed	
20c. TIME OF INJURY 5:15 p. m. Hour Month, Day, Year 8-22-56			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) office bldg.	
		20f. CITY, TOWN, OR LOCATION Aurora COUNTY Lawrence STATE Mo.	
21. I attended the deceased from 8-22-56 to 8-23-56 and last saw her her alive on 8-23-56 Death occurred at 11:00 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Howard J. Mason (Degree or title)		22b. ADDRESS Springfield, Mo 700 E. Sunshine	
		22c. DATE SIGNED 8-23-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 25, 1956	23c. NAME OF CEMETERY OR CREMATORY Goodhope Cemetery	23d. LOCATION (City, town, or county) (State) Goodhope Ill
24. FUNERAL DIRECTOR Oscar L. Marsh ADDRESS Aurora, Missouri		25. DATE RECD. BY LOCAL REG. 8-27-56	
		26. REGISTRAR'S SIGNATURE Emt. Williamson	

OCT 18 1956

OCT 17 1956

OCT 2 1956

OCT 2 1956

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.....
Murray Wilson

Licensed Embalmer No. 498

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.