

FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH4456
STATE FILE NUMBER

4456

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 48

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>				
b. CITY (If outside corporate limits, give TOWNSHIP OR TOWN) <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Noll Hospital</u>		Length of stay in lb <u>2 days</u>		d. STREET (If outside, give location) ADDRESS <u>N.W. of Albany</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Thornton</u> Middle <u>Delbert</u> Last <u>Ross</u>				4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1957</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 24, 1912</u>		9. AGE (In years last birthday) <u>44</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Day <u>21</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>Harrison County Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leslie Ross</u>				14. MOTHER'S MAIDEN NAME <u>Shella Madden</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Goldie Ross</u> Address <u>Albany, Mo.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lungs Pulmonary Neoplasm</u> DUE TO (b) <u>Seminoma</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 Months</u> <u>1 1/2 yrs</u>	
20a. ACCIDENT <input 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.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE			
21. I attended the deceased from <u>2-14-57</u> to <u>2-16-57</u> and last saw her/him alive on <u>2-16-57</u> Death occurred at <u>8:45 p</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>W. H. Brock</u> (Degree or title) <u>MO</u>				22b. ADDRESS <u>Bethany Mo</u>		22c. DATE SIGNED <u>2-18-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Feb 19 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grandview</u>		23d. LOCATION (City, town, or county) (State) <u>Albany, Missouri</u>			
24. FUNERAL DIRECTOR <u>Clifford Brooks</u> ADDRESS <u>Albany, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>2-20-57</u>		26. REGISTRAR'S SIGNATURE <u>Zola Burris</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health,
Welfare
Public
Service300
1-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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.....

Licensed Embalmer No.....

P. O. Address.....

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