

Health, Welfare
Public
Service

FILED AUG 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER
24201

Registration District No. **128** Primary Registration District No. **2000** Registrar's No. **763-A**

300
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Polk	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		c. CITY OR TOWN Halfway	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital		d. STREET ADDRESS Route 2	
3. NAME OF DECEASED (Type or print) ROSS		4. DATE OF DEATH Month JULY Day 28 , Year 1957	
5. SEX Male	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 April 15, 1989
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and state or country) Near Sentinel, Missouri
13a. FATHER'S NAME John Reser		13b. MOTHER'S MAIDEN NAME Nancy Brannon	14. NAME OF HUSBAND OR WIFE Maple Reser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 562-32-7276	17. INFORMANT Address Mrs. Gona Wilson Springfield, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) subsequent to surgery for DUE TO (c) Carcinoma of Ampulla of Vater			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1552			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 . Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input 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.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7-4-57 to 7-28-57 and last saw him alive on 7-28-57 Death occurred at 9:00 PM on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A. W. Hays (Degree or title)		22b. ADDRESS M. D. Springfield, Mo.	
		22c. DATE SIGNED 7-31-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 31, 1957	
23c. NAME OF CEMETERY OR CREMATORY Antiock Cemetery		23d. LOCATION (City, town, or county) (State) Near Pittsburg, Missouri	
24. FUNERAL DIRECTOR Erwin & Blue		25. DATE RECD. BY LOCAL REG. 8-5-57	
ADDRESS Bellevue, Mo.		26. REGISTRAR'S SIGNATURE Edith Williamson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

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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 *Harold B. Erwin*

Licensed Embalmer No. *3092*

P. O. Address *Palmita, Va.*

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.