

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031860
STATE FILE NUMBER

Filed OCT 14 1958 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1067

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN Milan	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #2		d. STREET ADDRESS (If outside, give location) 17 days	
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca Jane Ross		4. DATE OF DEATH Month Day Year October 6, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 26, 1881
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	11. BIRTHPLACE (City and state or country) Milan, Mo.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown Jacob Ross	
13b. MOTHER'S MAIDEN NAME unknown Elisha J. Warren		14. NAME OF HUSBAND OR WIFE ---	
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 Sarah Ross		Address Milan, 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) coronary insufficiency			INTERVAL BETWEEN ONSET AND DEATH 17 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Mal-Nutrition			unk.
DUE TO (c) Senility & General Debility			unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 Sept. 18, 1958 to Oct. 5, 1958 and last saw her alive on Oct. 5, 1958 Death occurred at 5:35 a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H F Mundy M.D.		22b. ADDRESS St Joseph Mo	
		22c. DATE SIGNED Oct. 6, 1958	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 10/6/1958	
23c. NAME OF CEMETERY OR CREMATORY Oak Wood Cemetery		23d. LOCATION (City, town, or county) (State) Milan Missouri	
24. FUNERAL DIRECTOR Hester - Bowman		25. DATE RECD. BY LOCAL REG. Oct. 6, 1958	
ADDRESS St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE Mrs. Clark Handell	

All diseases in Part I must be causally related.

Dr. H. F. Mundy

MEDICAL CERTIFICATION USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *John W. Herrick, Jr.*
Licensed Embalmer No. *4848*
P. O. Address *N. C. Mo.*

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.

Removed to: *Rigger Funeral Home.*