

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030744

FILED VS AUG 31 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **7406** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis	Length of stay in 1b	c. CITY OR TOWN Pagedale	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 607 N. Grand Avenue		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6508 Whitney
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)			First J.	Middle C.	Last ROSS	4. DATE OF DEATH Month August Day 5, Year 1959		
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/8/08	9. AGE (last birthday) 50	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Motors		11. BIRTHPLACE (City and state or country) Little Rock, Ark., U. S. A.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Buck Ross			13b. MOTHER'S MAIDEN NAME Martha			14. NAME OF HUSBAND OR WIFE Mildred Ross		

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. 489-16-7399	17. INFORMANT Mildred Ross		Address 6508 Whitney
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Convulsive seizure cause undet		50 min
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 St. Louis	COUNTY St. Louis	STATE Mo.
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21. I attended the deceased from **1-26-53** to **8-5-59** and last saw him alive on **8-5-59**
Death occurred at **9:45** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Albert Kaplan M.D.	(Degree or title)	22b. ADDRESS 607 N. Grand	22c. DATE SIGNED 8-7-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/1/59	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. AUG 1 0 59	26. REGISTRAR'S SIGNATURE Paul Smith M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Guyton Sw*

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.