

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-018218

STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 107

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUN 12 1961

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Chillicothe		c. CITY OR TOWN Norborne	
Length of stay in 1b 1 day		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Chillicothe City Hospital		d. STREET ADDRESS (If outside, give location) RFD	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Albert Marion Ross			4. DATE OF DEATH Month Day Year June 4, 1961
5. SEX Male	6. COLOR OR RACE Cauc. white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov 30 1892
9. AGE (last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper		10b. KIND OF BUSINESS OR INDUSTRY Retail General Mdse	11. BIRTHPLACE (City and state or country) Norborne, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME William Ross	
13b. MOTHER'S MAIDEN NAME Emma Johnson		14. NAME OF HUSBAND OR WIFE Nora Whitney Ross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Mrs. Albert Ross, Norborne, 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) Acute coronary occlusion			INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hours
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
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 a.m. p.m. Month, Day, Year			
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	COUNTY STATE
21. I attended the deceased from <u>June 3-61</u> to <u>June 4-61</u> and last saw ^{her} _{him} alive on <u>June 4-61</u> Death occurred at <u>726 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph F. Gale M.D.		22b. ADDRESS Chillicothe Mo	22c. DATE SIGNED 6-6-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-7-61	23c. NAME OF CEMETERY OR CREMATORY Antioch	23d. LOCATION (City, town, or county) (State) Norborne, Mo.
24. FUNERAL DIRECTOR ADDRESS Dickerson-Rice Bogard, Mo.		25. DATE RECD. BY LOCAL REG. June 6, 1961	26. REGISTRAR'S SIGNATURE Annalee Taylor

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 Samuel M. Rice

Licensed Embalmer No. 5087

P. O. Address Bogard, 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.