

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-023580

STATE FILE NUMBER

AMENDED

Registration District No. 317

Primary Registration District No. 348

Registrar's No. 1655

FILED JUN 21 1961

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		c. CITY OR TOWN <u>Webster Groves</u>	
Length of stay in 1b <u>YRS.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1105 So. Elm Ave.</u>		d. STREET ADDRESS (If outside, give location) <u>1105 So. Elm Ave.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>RALPH A. ROSS</u>			4. DATE OF DEATH Month Day Year <u>June 13, 1961</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>12/30/1889</u>	9. AGE (last birthday) <u>71</u>	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) <u>Stock Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind. Pkg. Co.</u>		11. BIRTHPLACE (City and state of country) <u>Cornwall Ontario Canada</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Wm. Ross</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Ainsworth</u>		14. NAME OF HUSBAND OR WIFE <u>Adeline Ross</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>W.W.I Canadian Army</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. R.A. Ross, 1105 So. Elm Ave. W.G. 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>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
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) <u>Diabetes mellitus</u>		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.)
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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 October 1958 to present and last saw ^{her} him alive on 6-9-61
Death occurred at 1 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Robert C. Kugeland</u>	(Degree or title) <u>MD</u>	22b. ADDRESS <u>14 Farney Walk Clayton 5, Mo</u>	22c. DATE SIGNED <u>6-14-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/15/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kirkwood, Mo.</u>
24. FUNERAL DIRECTOR <u>Parker-Aldrich, Webster Groves, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>6-14-61</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Murphy M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leslie Holch

Licensed Embalmer No. 4395

P. O. Address Holster Grove

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.