

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031073
STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7899**

FILED SEP 6 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN East St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1705 Missouri Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HATTIE Middle JANET Last ROSS			4. DATE OF DEATH Month August Day 23 Year 1961			
5. SEX Female	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 10/10/01	9. AGE (last birthday) 59	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) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Holly Springs, Miss. U.S.A.	12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME MAT JAMES	13b. MOTHER'S MAIDEN NAME NANNIE (UNKNOWN)	14. NAME OF HUSBAND OR WIFE GEORGE 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. Unknown	17. INFORMANT George Ross, 1705 Missouri, E. St. Louis	

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)	Thromboemboli of both femoral arteries	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Mural thrombosis of heart DUE TO (c) Hypertensive cardiovascular disease	
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. 42.01 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 8/23/61	COUNTY St. Clair	STATE
21. I attended the deceased from 7/26/61 to 8/23/61 and last saw her ^{her} _{him} alive on 8/23/61 Death occurred at 8/23/61 2:50 a. m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>Carl Vermillion, M.D.</i> (Degree or title)	22b. ADDRESS O. Vermillion, M. D. BARNES HOSPITAL	22c. DATE SIGNED 8/23/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/31/61	23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memories	23d. LOCATION (City, town, or county) (State) Stokey Twsp., Illinois
24. FUNERAL DIRECTOR <i>Marion Office</i> ADDRESS 2114 Missouri Ave. E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. AUG 24 1961	26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 Frank Prokopp

Licensed Embalmer No. 4356

P. O. Address St. Louis, 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.