

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

1187

-62-037749

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED OCT 24 1962

1. PLACE OF DEATH a. COUNTY BUCHANAN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOLT	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH		Length of stay in lb 11 DAYS	c. CITY OR TOWN MOUND City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. METH. HOSP		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last NANCY ELIZABETH ROSS			4. DATE OF DEATH Month Day Year OCT. 19, 1962	
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1881	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY IN THE HOME	11. BIRTHPLACE (City and state or country) BARNARD, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WILLIAM JOBE	13b. MOTHER'S MAIDEN NAME JANE REA	14. NAME OF HUSBAND OR WIFE ISAAC M. ROSS
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give service dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address ISAAC M. ROSS MOUND City, Mo.
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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: IMMEDIATE CAUSE (a) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH
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 checked="" 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 COUNTY STATE
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21. I attended the deceased from **10-9-62** to **Oct 19-62** and last saw her alive on **Oct 19-62**
Death occurred at **11:15 P** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D.P. Perry M.D.	22b. ADDRESS MOUND City Mo	22c. DATE SIGNED 10-20-62
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-23-62	23c. NAME OF CEMETERY OR CREMATORY MOUND City Mausoleum	23d. LOCATION (City, town, or county) (State) MOUND City Mo.
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24. FUNERAL DIRECTOR ADDRESS JAMES H. CRAWFORD MOUND City, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 22, 1962	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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Rev. 4/59
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
D.P. Perry, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

2961 2

NOV

Permit issued 10/20/62

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 James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mount City, 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.