

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

4689
Do not use this space.

791
1003

1382

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township Primary Registration District No.
 (c) City St. Louis (d) Street No. St. Johns Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

JOHN ROSS
 (a) Residence, No. 4700a Mc. Millan Ave. St. 12
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cora May Ross
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 25 1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 3 16

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. R. R. Clerk
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland 11

FATHER
 13. NAME James Ross 11

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland 11

MOTHER
 15. MAIDEN NAME Sophia Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scotland

17. INFORMANT (ADDRESS) Helene Ross
4700a Mc. Millan

18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles Cem. DATE Febr. 13 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Orchman Thoral
1905 Union Blvd.

20. FILED FEB 13 1939
J. B. Brudeck
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 11, 1939
 22. I HEREBY CERTIFY, That I attended deceased from April 15, 1936, to Feb. 11, 1939
 I last saw him alive on Feb. 11, 1939 Death is said to have occurred on the date stated above, at 10:27 m.
 The principal cause of death and related causes of importance were as follows:

Date of onset 1935
Myocarditis
Arterio-sclerosis 1928?
 Other contributory causes of importance:
None
 Name of operation Date of
 What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury kg

24. Was disease or injury in any way related to occupation of deceased? kg
 If so, specify
 (Signed) W. B. Kupper M. D.
 (Address) 4500 Alton St.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address.....

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 this body is not embalmed, above space should be left blank.