

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

7447
Do not use this space.

REC'D MAR 16 1939

1. PLACE OF DEATH

(a) County Pettis Registration District No. 668
 (b) Township _____ Primary Registration District No. 3032
 (c) City Sedalia (d) Street No. 403 East 6th. Registered No. 63
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 David Franklin Ross

(a) Residence, No. 403 East 6th. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 16, 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 9 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
 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) Iowa

13. NAME Jack Ross

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Rachel Cox

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

17. INFORMANT (ADDRESS) Cora McFadden
Stafford Kans.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Hill Cem. DATE Feb. 20, 1939.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Gillespie Funeral Home
Sedalia, Mo.

20. FILED 2-22-1939 Mrs Harry Sneed
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17, 1939, 19

22. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1939, to Feb. 17, 1939
 I last saw him alive on Feb 17, 1939 Death is said to have occurred on the date stated above, at 2 30 P. M.
 The principal cause of death and related causes of importance were as follows:

Chronic pneumonia from influenza
 Date of onset Feb 14/1939
 Other contributory causes of importance: Chronic valvular atherosclerosis
Chronic myocarditis

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chrom Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No 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 _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Chas. W. Sneed, M. D.
 (Address) Sedalia, Mo.

RECEIVED
District Health Officer No. 8,
District File Number
3/6/39
Filed

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,

L. E. Beudlin

or by

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

Signed *L. E. Beudlin*

Licensed Embalmer No. *3867*

P. O. Address *Sealala*

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.