DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34584

Registration District No. 1008 Primary Registration District No. _____ Registrar's No. 9122

1. PLACE OF DEATH:

(a) County _____ NOV 13 1939

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: H. F. Phillips Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ---
In this community ---
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

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(d) Street No. 2325 Spruce
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Katie Ross 200

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race N

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 9- (Month) 20- (Day) 39 (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, (City, town, or county) Mo. (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

FATHER
12. Name Albert Ross
13. Birthplace Mecca, (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Doris Moore
15. Birthplace Mecca, (City, town, or country) Miss. (State or foreign country)

16. (a) Informant's own signature Esther Mae Sherard
(b) Address 2601 N Whittier

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof 10-26-39 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director Ira Hamilton
(b) Address City Health Dept

19. (a) OCT 25 1939 (Date received local registrar) (b) O. F. Bellach (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9- day 20th year 1939 hour 7 minute 5 A. M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h alive on _____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Unknown (Stillborn) — Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature J. B. Martin (M. D. or other)
Address 2601 N Whittier Date signed 10-24-39

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I X19511

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.....

Licensed Embalmer No.....

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.