

MAR 2 1940
S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8158**

Registration District No. **784**

Primary Registration District No. **200**

Registrar's No. **429**

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **Overland**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Liberty & Ashby
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3**
(Specify whether years, months or days) **9 mo.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **St Louis**
(c) City or town **Overland**
(If outside city or town limits, write "RURAL")
(d) Street No. **Lackland & Ashby**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME **Robert Ross** **260**

3. (b) If veteran, name war **//////////** 3. (c) Social Security No. **//////////**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Maude Ross** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Dec 30 1858**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 **1** **28** hr. min.

9. Birthplace **St James Mo** (City, town, or county) (State or foreign country) **0**

10. Usual occupation **retired carpenter** **9**

11. Industry or business **9**

MOTHER { 12. Name **Robert Ross**

13. Birthplace **Do not know** (City, town, or county) (State or foreign country)

14. Maiden name **Do not know**

15. Birthplace **Do not know** (City, town, or county) (State or foreign country)

16. (a) Informant **Maude Ross**

(b) Address **Overland Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Mar 2 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Lake Charles**

18. (a) Signature of funeral director **Ortmann Funeral Home**

(b) Address **9222 Lackland Overland Mo**

19. (a) **MAR 2 - 1940** (Date received local registrar) (b) **D.R. Meyer M.D.** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **28** year **1940** hour **2:00** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **July 15**, 19**40**, to **July 28**, 19**40**; that I last saw him alive on **July 28**, 19**40**; and that death occurred on the date and hour stated above.

Immediate cause of death **Heart Failure**
myocardial

Due to **Senility**

Due to **Survive Cold for 5 days**

Other conditions **July 15 he had pneumonia attack**
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations **none**
Of autopsy: **✓**
9301

22. If death was due to external causes, fill in the following: **no**

(a) Accident, suicide, or homicide (specify) **no**

(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? _____

While at work? **no** (Specify type of place) (e) Means of injury _____

23. Signature **W.D. Warburg** (M. D. or other) **1**

Address **1275-9 Oakington** Date signed **3-28-40**

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

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 Alb. Outmann

Licensed Embalmer No. 3478

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.