

JUN 6 1940  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3025

Registrar's No. 41

1. PLACE OF DEATH

(a) County Linn  
(b) City or town Brassfield Mo.  
(c) Name of hospital or institution McFarley Hospital  
(d) Length of stay: In hospital or institution 3 weeks  
In this community 54 yrs

8. (a) PRINT FULL NAME John Ross 2nd

3. (b) If veteran, name war \_\_\_\_\_ 8. (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 FLORENCE ROSS 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Aug 10 1852

8. AGE: Years 87 Months 7 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Thurso Scotland

10. Usual occupation Farming

11. Industry or business Same  
12. Name Sagey Ross  
13. Birthplace Thurso Scotland  
14. Maiden name Kathleen  
15. Birthplace Thurso Scotland

16. (a) Informant Linnell Dillard  
(b) Address New Cambria Mo

17. (a) Burial (b) Date thereof May 11 1940  
(c) Place: burial or cremation High Hill Cem

18. (a) Signature of funeral director Edson  
(b) Address Brassfield Mo

19. (a) May 11-40 (b) John Dillard

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn  
(c) City or town Brassfield Mo.  
(d) Street No. 6 miles So. East  
(e) If foreign born, how long in U. S. A? 25 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
year 1940 hour 5 P.M. M.

21. I hereby certify that I attended the deceased from 4/16, 1940, to 5/7, 1940, that I last saw him alive on 5/8/40, and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction  
Due to Hypertension - Atherosclerosis  
Due to 2 spots leg! heart  
Other conditions (include pregnancy within 3 months of death) 0

Major findings: Of operations none  
Of autopsy same

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) 0  
(b) Date of occurrence 0  
(c) Where did injury occur? 0  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0  
While at work? 0 (Specify type of place) (e) Means of injury 0  
23. Signature J. D. Dillard (M. D. or other) 1  
Address Brassfield, Mo Date signed 5/11/40

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

MOTHER FATHER

122  
101

RECEIVED  
District Health Officer No. 111  
District File Number 640-818  
Date Filed JUN 4 1940

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 W. Larson  
Licensed Embalmer No. 4037  
P. O. Address Bucklin 72

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 18892

Registration District No. H96

Primary Registration District No. 3025

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Linn  
(b) City or town Brownfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months \_\_\_\_\_ days)

3. (a) PRINT FULL NAME

John Ross

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 87 Months 7 Days 18 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 Uremia

Due to Hypertension - 131  
Due Pr. distended hepatic

Other conditions Infected leg  
(Include pregnancy within 6 months of death)  
N. M. D.

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature J. M. McFarney (M. D. or other) \_\_\_\_\_  
Address Brownfield Mo signed \_\_\_\_\_

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

SUPPLEMENTAL

S-18892