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12-40
7-39
X23152

Registration District No. **99**

Primary Registration District No. **544 3016**

Registrar's No. **77**

1. PLACE OF DEATH:
(a) County **Franklin**
(b) City or town **Washington Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Francis Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **one day** (Specify whether years, months or days)
In this community **Seven Months**

3. (a) PRINT FULL NAME **Gladys Marie Ross**
3. (b) If veteran, name war **X** 3. (c) Social Security No. **X**

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

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

7. Birth date of deceased: **January 10 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 7 5 hr. min.

9. Birthplace **Berkeley Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **X**

11. Industry or business **X**

12. Name **Louis L Ross**

13. Birthplace **New York N.Y.** (City, town, or county) (State or foreign country)

14. Maiden name **Annie Mitelda Reed**

15. Birthplace **Owensville, Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Annie M. Kramer**

(b) Address **Campbellton, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug. 16th 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Owensville, Mo**

18. (a) Signature of funeral director **Nieburg & Wilbur, by S. H. Witt**

(b) Address **Washington, Mo**

19. (a) **Aug. 15 1940** (Date received local registrar) (b) **H. A. May** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Franklin**
(c) City or town **Washington, Mo Rural #1 West** (If outside city or town limits, write "RURAL")
(d) Street No. **P. O. #1 West** (If rural, give location)
(e) If foreign born, how long in U. S. A.? **X** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **15** year **40** hour **35** minute **30** A. M.

21. I hereby certify that I attended the deceased from **8/14/40**, 19... to **8/15**, 19... that I last saw her alive on **8/15/40** and that death occurred on the date and hour stated above.

Immediate cause of death **Talent Trochanter Osteo** Duration

Due to **1570**

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? While at work? (Specify type of place) (e) Means of injury

23. Signature **J. J. Post** (M. D. or other) **M.D.**

Address **W. Pottington Mo.** Date signed **8/15/40**

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

MOTHER FATHER

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 Me

working under my personal supervision. Registered Apprentice No.

Signed Lester A. Vitt

Licensed Embalmer No. 3254

P. O. Address Washington, Mo.

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, fact should be so stated above.