FILED OCT 11 1940

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30921

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3481

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 615 Ewing Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution -- (Specify whether N)

In this community 55 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. 615 Ewing (O)
(If rural, give location)

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

3. (a) PRINT FULL NAME: ALBERT A. ROSS

3. (b) If veteran, name war: None — Albert A. Ross

3. (c) Social Security No. 495-03-0710

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Cordelia Jane Ross

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

7. Birth date of deceased: Oct. 3, 1869 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	11	0	hr. ____ min.

9. Birthplace: Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation: Engineer

11. Industry or business: Sheffield Steel Corp.

FATHER
12. Name: Scott Ross
13. Birthplace: Ky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Margaret Austin
15. Birthplace: Ky
(City, town, or county) (State or foreign country)

16. (a) Informant: Alvin A. Ross
(b) Address: 11101 E 24 Highway, K.C.Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Sept. 5-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Oklahoma City, Okla.

18. (a) Signature of funeral director: C.H.Blackman & Son, Inc.
(b) Address: Sept 5, 1940

19. (a) ____ (Date received local registrar) (b) M. M. Brome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ____ day 9-3-40
year ____ hour ____ minute 2-10 A. M.

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

Immediate cause of death — Duration

Cerebellar ~~[illegible]~~ Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death): 42 hr

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? (Specify type of place) (Means of injury)

23. Signature: Forrest Chilton (M. D. or other)
Address: K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 H B Blackman

Licensed Embalmer No. 3639

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.