

S. No. 2  
OM-8-13  
Ev. 5-17-39  
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UNITED STATES HEALTH DEPARTMENT  
STANDARD CERTIFICATE OF DEATH

State File No. 2301

**FILED FEB 7 1946**  
Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 58

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

14  
12

299

**1. PLACE OF DEATH:**

(a) County Callaway

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

(c) Name of hospital or institution:  
State Hosp. No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 yrs 9 mos 7 days  
(Specify whether years, months or days)

In this community 10 yrs 9 mos 7 days  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Earl Ross

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 single

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: March 28 1915  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>30</u>	<u>8</u>	<u>27</u>	hr. _____ min. _____

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

10. Usual occupation none

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

**MOTHER FATHER**

12. Name M. P. Ross

13. Birthplace Hurdland Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Brew

15. Birthplace Adair Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant M. P. Ross

(b) Address Hurdland Mo

17. (a) Removal (b) Date thereof 1/25/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hurdland, Mo

18. (a) Signature of funeral director Wallace Funeral Home  
(Specify type of place) While at work? (c) Means of injury \_\_\_\_\_

(b) Address Fullon, Mo

19. (a) 1-25-1946 (b) Jessie Morsink Huff  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Adair 14

(c) City or town Hurdland (rural)  
(If outside city or town limits, write "RURAL")

(d) Street No. Rural  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 25 year 1946 hour 2 minute 40 A. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945 to Jan 25, 1946; that I last saw him alive on Jan 24, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to Stroke Epilepsy

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? \_\_\_\_\_

23. Signature Forest Thomas (M. D. or other) \_\_\_\_\_  
Address Fullon, Mo Date signed 1/25/46

RECEIVED  
District Health Officer No. 3  
District File Number \_\_\_\_\_  
Date Filed 2-5-46

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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 Kenil C. Browning  
Licensed Embalmer No. 2724  
P. O. Address Fulton 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.**