

**FILED FEB 3 1946**

5-5-00

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **1**

**1. PLACE OF DEATH:**

(a) County HARRISON  
 (b) City or town RURAL UNION TWP.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (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 or days

3. (a) PRINT FULL NAME GEORGE MARTIN 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 WIDOWED

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

7. Birth date of deceased 6-18-1855  
 (Month) (Day) (Year)

8. AGE: Years 90 Months 6 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business Retired

12. Name JOSEPH 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 Lloyd Ross

(b) Address Ridgeway, Mo.

17. (a) BURIAL (b) Date thereof 9/5/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation AKRON, COLO.

18. (a) Signature of funeral director S. M. Hays

(b) Address Bethany, Mo.

19. (a) 1-7-46 (b) Richard Ashair  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MISSOURI (b) County HARRISON  
 (c) City or town RURAL  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. UNION TWP.  
 (If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 1 day 1  
 year 1946 hour 6 minute P.M.

21. I hereby certify that I attended the deceased from 12-9-45 to 1-1-46  
 that I last saw him alive on 1-1-46  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 13/10  
 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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Ralph L. Walker (M. D. or other) DO  
 Address Bethany, Mo. Date signed 1-2-46

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

MOTHER FATHER

*J. Haas*  
*Adm.*

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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..... *Thomton H. Haas*.....

Licensed Embalmer No. *2861*.....

P. O. Address..... *Bethany, 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.**

Registration District No. 136 Primary Registration District No. 5000

1. PLACE OF DEATH:  
(a) County Harrison  
(b) City or town Rural Union Twp  
(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 or days

3. (a) PRINT FULL NAME George M. 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 wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased June (Month) 1946 (Year)

8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Hammer Iowa (City, town, or county) (State or foreign country)

10. Usual occupation retired

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 \_\_\_\_\_

(a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) Chas Adair  
(Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other)  
Date signed \_\_\_\_\_

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

MOTHER FATHER

741

SUPPLEMENTARY

2824