DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39028

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9812

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
Homer G Phillips Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0-0-0

(c) City or town St. Louis 2517
(If outside city or town limits, write "RURAL")

(d) Street No. 1113½ N 12th St 90
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Eugene Ross

3. (b) If veteran, name war No

3. (c) Social Security No 497-10-4292

4. Sex Male 2

5. Color or race Col

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 Feb (Month) 14 (Day) 1878 (Year)

8. AGE: Years 68 Months 8 Days 30 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business Saborer

FATHER
12. Name Eugene Ross
13. Birthplace Dont Know Miss (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Martha Monroe
15. Birthplace (City, town, or county) Miss (State or foreign country)

16. (a) Informant Ada Silver
(b) Address 1103 12 Blvd

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-20-46 (Month) (Day) (Year)
(c) Place: burial or cremation E St Louis Ill

18. (a) Signature of funeral director N. W. Kreuer
(b) Address 3517 Laclede Ave

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13
year 1946 hour 11 minute 40 A M.

21. I hereby certify that I attended the deceased from 11-9, 1946, to 11-13, 1946
that I last saw him alive on November 13, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease with Decompensation — Duration Undet.

Due to

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Yes

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? (f) Means of injury O

23. Signature E. B. Williams (M. D. or other)
Address 2601 N Whittier Date signed 11/14/46

(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 .....

Licensed Embalmer No. 1173

P. O. Address 351 Sackett Ave

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

If this body is not embalmed, fact should be so stated above.

NOV 18 1940

S. No. 2B
M—3-45
I X43880

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

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STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9812

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME Eugene Ross
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race B
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 14 1877
(Month) (Day) (Year)
8. AGE: Years 68 Months 8 Days 30 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country) Mo
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 11-18-1946 (Date received local registrar) (b) J F Bredeck (Registrar's signature) DEC 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 3 year 1946 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 — Duration
Due to
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

39028

ME - 0707