

No. 2  
-12-45  
-17-39  
X47070

FILED JAN 27 1947 318

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County St. Louis

(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  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Isadore Spencer Ross

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 2 5. Color or race Negro 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 May 1 1946  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
8 mos 11 hr. min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name Ozale Ross

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

14. Maiden name Eleanor Spencer

15. Birthplace Miss.  
(City, town, or county) (State or foreign country)

16. (a) Informant Eleanor Spencer  
(b) Address 2800 E MARKET

17. (a) Shipped (Burial, cremation, or removal) (b) Date thereof JAN 15/47  
(Month) (Day) (Year)

(c) Place: burial or cremation ARTESIA, MISS.

18. (a) Signature of funeral director E. A. GREEN  
(b) Address 2915 FRANKLIN AVE

19. (a) JAN 14 1947 (Date received local registrar) (b) J. S. Green (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 2300

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

(d) Street No. 2800 Market St  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12  
year 1947 hour 7 minute 45 AM

21. I hereby certify that I attended the deceased from 1-10, 1947, to 1-12, 1947  
that I last saw him alive on Jan. 12, 1947,  
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia (Bilateral)  
Primary

Duration Undet.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No

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)

(c) Means of injury \_\_\_\_\_

Signature Sheadare Reving (M. D. or other) \_\_\_\_\_

Address 2601 N Whittier Date signed 1/13/47

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

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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.....

**F. A. GREEN**

Licensed Embalmer No.....

**2963**

P. O. Address.....

**2915 FRANKLIN**

**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.**