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Dr. S. D. Smith
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3930

State File No. _____

Registrar's No. 68

Registration District No. 38

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution:
1018 Jefferson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 5 months years, months or days)

3. (a) PRINT FULL NAME Joseph Walter ROSS

3. (b) If veteran, name war no

3. (c) Social Security No. _____

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife Anna May Smith

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

7. Birth date of deceased Jan 31 1873
(Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 6
If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER

12. Name Tom Ross

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

14. Maiden name Elizabeth Mary Swartz

15. Birthplace Cooper County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Hammond

(b) Address 1008 Jefferson Columbia Mo

17. (a) Burial (b) Date thereof 3 8 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Physician Cemetery

18. (a) Signature of funeral director Chas. J. Gordon

(b) Address Jefferson City

19. (a) 3-16-47 (b) Mrs. R. E. Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 / Day 6 - March
Year 1947 Hour 6 minute 25

21. I hereby certify that I attended the deceased from 3/4 to 3/4 1947
that I last saw him alive on 3/4 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy 7 days
cerebral arterio
sclerosis
high blood
pressure

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Duration

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? _____

(Specify type of place) _____
While at work _____ (c) Means of injury _____

23. Signature Stephen D. Neeth (M. D. or other) _____
Address Columbia Mo Date signed 3/6/47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3/10/47

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 *Wm. L. Jones Jr.*

Licensed Embalmer No. *4471*

P. O. Address *W. L. Jones Jr.*

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.