

2
43
7-30
X33597

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40677
Registrar's No. 36

FILED NOV 19 1947

Registration District No. 37

Primary Registration District No. 6175

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

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Harris - Liberty 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 years, months or days)

In this community 69 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan

(c) City or town Harris - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Liberty Twp
(If rural, give location)

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

3. (a) PRINT FULL NAME James O. 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 Married

6. (b) Name of husband or wife Anna Chapman 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Aug 31 1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Jacob Ross

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

14. Maiden name Jane Warren

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

16. (a) Informant Mrs Anna Ross

(b) Address Milan - Mo

17. (a) Burial (b) Date thereof 10-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beardstown

18. (a) Signature of funeral director Schaerer

(b) Address Milan Mo

19. (a) Nov. 15 47 (b) Arto Caldwell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3 year 1947 hour 10 minute 45 a.m.

21. I hereby certify that I attended the deceased from March 3, 1947, to Oct. 3, 1947, that I last saw him alive on Sept 30, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of lower colon & rectum

Due to _____

Due to _____

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

Major findings: Of operations None

Of autopsy _____

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 0

23. Signature J. S. Montgomery (M. D. or other)

Address 1 Milan Mo Date signed _____

Duration about 18 Mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

Health Officer No. 10

11-47-1596

NOV 18 1947

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 Dwight Schauer

Licensed Embalmer No. 2667

P. O. Address Melan Wis

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.