

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11389**BIRTH NO. _____ REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **130**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gibbe	
d. FULL NAME OF HOSPITAL OR INSTITUTION Laughlin Hospital		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) FRANK		4. DATE OF DEATH (Month) (Day) (Year) 4-29-49	
a. (First) _____ b. (Middle) F c. (Last) ROSS			
5. SEX MO	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 2-26-1866
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Hancock Co. Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13a. FATHER'S NAME F.M. ROSS	13b. MOTHER'S MAIDEN NAME JULIA BRESSING	14. NAME OF HUSBAND OR WIFE Allie Ross
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no; or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Allie Ross ADDRESS Gibbe, Mo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH ?
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) _____		DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				4201

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **April 26, 1949**, to **April 29, 1949**, that I last saw the deceased alive on **April 29, 1949**, and that death occurred at **8:10 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE A. J. Rhoads, M.D. (Degree or title)	23b. ADDRESS 200 Kirkville, Mo.	23c. DATE SIGNED 4-29-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-1-49	24c. NAME OF CEMETERY OR CREMATORY Wilson Cemetery
24d. LOCATION (City, town, or county) (State) 6 mi. S. Brainerd, Mo.		
DATE REC'D BY LOCAL REG. 5-1-49	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Foster P. Easley ADDRESS Brainerd, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer

District File Number 54
Date Filed MAY 1 0 19

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.