

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6672

FILED FEB 17 1950

State File No. 824

#105705

BIRTH NO. REG. DIST. NO. 214 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 2278 1303 SPRUCE STR.	

3. NAME OF DECEASED (Type or Print)	a. (First) WILLIAM	b. (Middle)	c. (Last) ROSS	4. DATE OF DEATH (Month) (Day) (Year) OF DEATH January 21, 1950
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED UNKNOWN	8. DATE OF BIRTH UNKNOWN- <del>08</del> -29	9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 4 HRS. Hours	13. IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GARAGE MAN	10b. KIND OF BUSINESS OR INDUSTRY TRUCKING CO.	11. BIRTHPLACE (State or foreign country) BOSTON MASS.	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME FRANK ROSS	13b. MOTHER'S MAIDEN NAME BRIDGET Mc'KAY	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 491-14-8849	17. INFORMANT'S SIGNATURE OR NAME MISS. HILDA DIERKES	ADDRESS 1303 SPRUCE
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach with		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) generalized metastases.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 157X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1/21/50 7:25am	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 11/22/49, 19 to 1/21/50, 19, that I last saw the deceased alive on 1/21/50, 19, and that death occurred at 9:25am, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Wain Hendlin M.D.	23b. ADDRESS 1515 Lafayette Ave., 1/21/50	23c. DATE SIGNED
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24a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	24b. DATE JAN. 27TH	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 26 1950 J. B. Lanter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brockland Und. Co. 1827 HOGAN STR.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Elmer R. Sadwell*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4077

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.