

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

STATE FILE NUMBER

38075  
9486

Registration District No. 318 Primary Registration District No.

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP.#1.</b>		Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>4386 Laclede Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>JULIA S. ROSS</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>10</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1871</b>	9. AGE (In years as of birthday) <b>85</b>	10. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Collinsville, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Schlabach</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Robert D. Ross</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Robert J. Ross</b>		Address <b>7508 Leadale</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>old Pulmonary embolus</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED.. (Enter nature of injury in PART I or PART II of item 18.) <b>420.0</b>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>		COUNTY <b>St. Louis</b>		STATE <b>Missouri</b>	
21. I attended the deceased from <b>9/17/57</b> to <b>10/10/57</b> and last saw her/him alive on <b>10/10/57</b> Death occurred at <b>3:30 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>A E Del</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>10/10/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 12, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	
23d. LOCATION (City, town, or county) <b>St. Louis County</b>		23e. STATE <b>Missouri</b>		24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b>	
25. DATE RECD. BY LOCAL REG. <b>OCT 11 1957</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
X  
by me, or by ....., Student Embalmer No. ....  
working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed

*Robert Wheeler*

Licensed Embalmer No. *2128*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.