

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-009471

STATE FILE NUMBER

FILED APR 15 1958

Registration District No. 120

Primary Registration District No. 4194

Registrar's No. 196

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Albany,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>New Hampton 0380</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Albany Rest Home</b>		Length of stay in lb <b>4 mos.</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Elizabeth</b> Last <b>Ross</b>			4. DATE OF DEATH Month <b>April</b> , Day <b>6</b> , Year <b>1958</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</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>Jan. 22, 1885</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Unknown 9</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Frank H. Webster</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Johnson</b>	14. NAME OF HUSBAND OR WIFE <b>Daniel Ross</b>
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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 Address <b>Albany Rest Home, Albany, Mo.</b>
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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>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>2</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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 COUNTY STATE
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21. I attended the deceased from Death occurred at <b>April - 3 - 58</b> to <b>April 5 - 58</b> and last saw her alive on <b>4 - 5 - 58</b> at <b>4:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>C. J. Pray, D.O.</b> (Degree or title)	22b. ADDRESS <b>Albany, Mo.</b>	22c. DATE SIGNED <b>4-7-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>April 7 - 58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Providence, Rhode Island</b>
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24. FUNERAL DIRECTOR <b>Clifford Brooks, Albany, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>4-8-1958</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. L. W. Bare</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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Doctor, coroner, etc.: must use only "Standard" All diseases in Part I must be causally related.

APR 17 1958

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 me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed Donald E. Coakley.....

Licensed Embalmer No. 4868.....  
P. O. Address Albany, Mo......

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.