

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015641

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 3918**

FILED MAY 6 1959

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BOONE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>ST. LOUIS</u> Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>STURGEON</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION <u>PARK LANE HOSP</u> <u>6 DAYS</u>		d. STREET ADDRESS (If outside, give location) Reside on Farm <u>STAR ROUTE</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle _____ Last <u>ROSS</u>			4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>1959</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1886</u>	9. AGE (In years and birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>STATE HIGHWAY MAINTENANCE</u>	11. BIRTHPLACE (City and state or country) <u>ST. CHARLES, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13. FATHER'S NAME <u>JOSEPH ROSS</u>	14. MOTHER'S MAIDEN NAME <u>MATILDA SCROGGINS</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Emilie Ross, Sturgeon Mo</u>
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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) <u>Congestive Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of Liver</u>	
	DUE TO (c) <u>1561</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____	20d. 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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20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>4-14-59</u> to <u>4-19-59</u> and last saw her alive on <u>4-19-59</u> Death occurred at <u>5:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>4930 Lindell Blvd.</u>	22c. DATE SIGNED <u>4-21-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>4-19-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>	23d. LOCATION (City, town, or county) (State) <u>GRANITE CITY, ILLINOIS</u>
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24. FUNERAL DIRECTOR <u>Shinton C. Williams Granite City, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>APR 21 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

Use only black ink or ribbon typewrite if possible. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be causally related.

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MEDICAL CERTIFICATION

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.....
Signature of Student Embalmer

Signed *Spurston C. Skillman*

Licensed Embalmer No. 50

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.