

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1960

-60-009206

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 511 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7563 York Drive</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Clayton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>7563 York Drive</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
---	--	--	--

3. NAME OF DECEASED (Type or print) First <u>Lela</u> Middle <u>M.</u> Last <u>Ross</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14,</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>Muncie Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George E. Meredith</u>		13b. MOTHER'S MAIDEN NAME <u>Martha P. Jellison</u>		14. NAME OF HUSBAND OR WIFE <u>Herbert O. Ross</u>		
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. <u>none</u>		17. INFORMANT Address <u>Ladue Missouri</u> <u>Herebert M. Ross 27 Woodcrest Drive</u>		

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>Natural Causes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N <input type="checkbox"/> Unknown		
---	--	--	--	--

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.) _____			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at 11:25 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>John C. Murphy MD Asst. Health Commissioner</u>	22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>	22c. DATE SIGNED _____
---	---	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>Feb. 15, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri.</u>
--	--	---	---

24. FUNERAL DIRECTOR ADDRESS <u>C.R. Lupton and Sons 7233 Delmar Blv'd.</u>	25. DATE RECD. BY LOCAL REG. <u>2-15-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence H. New

Licensed Embalmer No. *4011*

P. O. Address *H. Linn*

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.