

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045595
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 453

AMENDED

FILED JAN 9 1961

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		c. CITY OR TOWN Hannibal	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital		d. STREET ADDRESS (If outside, give location) 4908 College	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last EARL HARRY ROSS			4. DATE OF DEATH Month Day Year December 21 1961			
--	--	--	---	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH April 21 1905	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months 8 Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	--	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	10b. KIND OF BUSINESS OR INDUSTRY Earl Ross Electrical Co.	11. BIRTHPLACE (City and state or country) Hannibal Missouri	12. CITIZEN OF WHAT COUNTRY U S A
---	--	--	---

13a. FATHER'S NAME Harry H. Ross	13b. MOTHER'S MAIDEN NAME Pearl Welch	14. NAME OF HUSBAND OR WIFE Polly Brown Ross
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address Mrs. Carl H. Ross Hannibal Missouri
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, multiple lung abscesses, bilateral		INTERVAL BETWEEN ONSET AND DEATH one week
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) Valvular heart disease, cardiac decompensation, generalized exfoliative dermatitis.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <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 **2:30 P** _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>W. J. Roller</i> (Degree or title) M.D.	22b. ADDRESS Hannibal, Missouri	22c. DATE SIGNED Dec 22/61
---	---	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Dec. 23, 1961	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Hannibal Missouri
--	-----------------------------------	--	---

24. FUNERAL DIRECTOR W. Crawford Smith Hannibal Missouri	ADDRESS	25. DATE RECD. BY LOCAL REG. Dec. 26, 1961	26. REGISTRAR'S SIGNATURE <i>Dr. E. M. Lucke by Lillian M. Sherman</i>
--	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AWIENED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

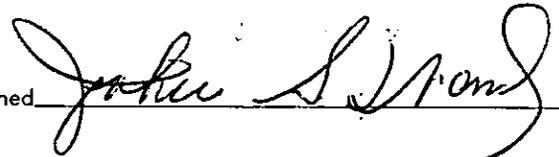
STATEMENT BY LICENSED EMBALMER

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

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4540

P. O. Address Hannibal Missouri

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.