

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-046556

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 545 Registrar's No. 3478

| | | | | |
|----------------|--------------|--|-----------------------|----------|
| VS 300 | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT |
| Rev. 4/59 | | | | |
| 1 <u>4004</u> | | | | |
| 2 <u>4004</u> | | | | |
| 3 | | | | |
| 4 <u>1</u> | | | | |
| 5 <u>1</u> | | | | |
| 6 | | | | |
| 7 <u>0</u> | | | | |
| 8 <u>2</u> | | | | |
| <u>9490X</u> | SHOULD READ | BY AFFIDAVIT OF | MEDICAL CERTIFICATION | ITEM NO. |
| 10 | | | | |
| 11 | | | | |
| 12 <u>90-0</u> | | | | |
| 13 | | | | |
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|---|--|---|-----------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY <u>St. Louis</u> | | a. STATE <u>Missouri</u> | | b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maplewood</u> | | Length of stay in lb <u>26 yrs.</u> | | c. CITY OR TOWN <u>Maplewood</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3530 Oxford</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>3530 Oxford</u> | |
| 3. NAME OF DECEASED | | 4. DATE OF DEATH | | Month Day Year | |
| First Middle Last <u>Flora Barbara Ross</u> | | <u>Nov 9 1963</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (last birthday) | IF UNDER 1 YEAR |
| <u>Female</u> | <u>White</u> | | <u>10-10-1900</u> | <u>63</u> | Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | |
| <u>Housewife</u> | | <u>Own Home</u> | | <u>St. Louis, Mo.</u> | |
| 12. CITIZEN OF WHAT COUNTRY | | 14. NAME OF HUSBAND OR WIFE | | | |
| <u>USA</u> | | <u>Leland Ross</u> | | | |
| 13a. FATHER'S NAME | | 13b. MOTHER'S MAIDEN NAME | | 17. INFORMANT | |
| <u>Otto C. Boerner</u> | | <u>Sophia Dill</u> | | <u>Leland Ross</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi) | | 16. SOCIAL SECURITY NO. | | Address | |
| <u>No</u> | | <u>None</u> | | <u>Leland Ross</u> <u>Above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | | | | | <u>48 hrs</u> |
| 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) | | | | PART III. If deceased was female was there a pregnancy in last 90 days. | |
| <u>Cerebral arteriosclerosis</u> | | | | <input type="checkbox"/> Yes <input checked="" 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.) | |
| | | | | <u>no injury</u> | |
| 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 | | STATE |
| | | | | | |
| 21. I attended the deceased from <u>3-10-1963</u> to <u>11-9-1963</u> and last saw her <u>alive</u> on <u>11-8-1963</u> | | | | | |
| Death occurred at <u>12:00</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) | | 22b. ADDRESS | | 22c. DATE SIGNED | |
| <u>Thos. J. Stines Jr. M.D.</u> | | <u>1418 Franklin, St. Louis Mo</u> | | <u>11-9-1963</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Removal</u> | <u>11-10-1963</u> | <u>City Cemetery</u> | | <u>Hardin, Ill.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | |
| <u>JAY B. SMITH, Maplewood, Mo.</u> | | <u>11-10-63</u> | | <u>John B. Murphy M.D.</u> | |

USE BLACK INK OR TYPEWRITER RIBBON

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 Melvin Barteau

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.