

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-047259
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 366

FILED DEC 23 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY Callaway			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pettis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fulton		Length of stay in lb 7 1/2 months	c. CITY OR TOWN Sedalia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2508 West 32nd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Grace Middle L Last ROSS			4. DATE OF DEATH Month Dec. Day 19 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1882	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) matron		10b. KIND OF BUSINESS OR INDUSTRY County Court	11. BIRTHPLACE (City and state or country) Colorado	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME S.A. Ross		13b. MOTHER'S MAIDEN NAME Louise Ray		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address State Hospital No. 1, Fulton, Mo.		
18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic brain syndrome DUE TO (b) brain - infarction DUE TO (c) advanced arteriosclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					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) heart - inactive rheumatic valvulitis					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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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	COUNTY	STATE
21. X attended the deceased from State Hospital No. 1 3-6-1963 to 12-19-63 and last saw him alive on X X X X X X X X X X Death occurred at 1:45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Fred. Handler M.D.			22b. ADDRESS Fulton, Missouri		22c. DATE SIGNED 12/19/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-21-63	23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery	23d. LOCATION (City, town, or county) (State) Sedalia, Mo.		
24. FUNERAL DIRECTOR Ewing Funeral Home Sedalia, Mo.		ADDRESS	25. DATE RECD. BY LOCAL REG. Dec 19 1963	26. REGISTRAR'S SIGNATURE Martha Lawrence	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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STATE OF MISSOURI

10-14

XSEE

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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 R. E. Baker

Licensed Embalmer No. 2419

P. O. Address Leola, 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.