WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pass

Township W Peculiar
or
Village ~~Peculiar~~
or
City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 162

Primary Registration District No. ~~4564~~ 5227

File No. 15934

Registered No. 6

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ramsey

PERSONAL AND STATISTICAL PARTICULARS

SEX male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH May 27, 13 (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day 12 hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

BIRTHPLACE (City or town, State or foreign country) Peculiar Mo

PARENTS

NAME OF FATHER Walter C. Ramsey

BIRTHPLACE OF FATHER (City or town, State or foreign country) Peculiar Mo

MAIDEN NAME OF MOTHER Adaline Vokes

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Peculiar Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Ramsey

(ADDRESS) Peculiar Mo

Filed May 28, 1913 H A Brierly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 28, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

~~Chaf on~~ 12

Cerebral Hemorrhage

160 B (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) Forceps Delivery

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H A Brierly M.D.

May 28, 1913 (Address) Peculiar Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Peculiar Cemetry

DATE OF BURIAL May 28, 1913

UNDERTAKER Arton & Mills

ADDRESS Peculiar Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER
(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER
(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS