

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

PLACE OF DEATH

County Green

Township Jackson

Village \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_ St.: \_\_\_\_\_ Ward)

Registration District No. 944

File No. 8277

Primary Registration District No. 5447B

Registered No. Four

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

FULL NAME Ralph R. Ricketts

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE Single  
MARRIED  
WIDOWED  
OR DIVORCED  
(Write the word)

DATE OF BIRTH July 4, 1912  
(Month) (Day) (Year)

AGE 2 yrs. 7 mos. 29 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) Green R., Mo.

NAME OF FATHER L. C. Ricketts

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) W. B. Brown

(ADDRESS) St. Charles

Filed 3-9 1915 Joseph Foster REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March 3, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 28, 1915, to March 3, 1915, that I last saw him alive on March 2, 1915, and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH\* was as follows:  
Diphtheria

(Duration) yrs. mos. 5 ds.

Contributory (SECONDARY) None  
(Duration) yrs. mos. ds.

(Signed) Frederic G. Stuart M. D.  
8-3 1915 (Address) St. Charles 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 Danforth DATE OF BURIAL 3-4 1915

UNDERTAKER Wm Whitmore ADDRESS Stratford Mo

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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATED UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH  
County Greene  
Township Jackson  
Village \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 944 File No. \_\_\_\_\_  
Primary Registration District No. 5447 B Registered No. 27

FULL NAME Ralph P. Ricketts (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

DATE OF DEATH March 3, 1915  
(Month) (Day) (Year)

DATE OF BIRTH July 4, 1912  
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from Feb 25, 1915, to March 3, 1915, that I last saw him alive on March 2, 1915, and that death occurred, on the date stated above, at 6 a.m.

AGE 29 yrs. 2 mos. 29 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Supplier  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

Diphtheria  
(Duration) \_\_\_ yrs. \_\_\_ mos. 3 ds.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

Contributory None  
(Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

NAME OF FATHER Linnel C Ricketts

(Signed) A H Street M. D.  
3-3, 1915 (Address) Stratford Mo

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

MAIDEN NAME OF MOTHER Stacy Palmer

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

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

(Informant) W R Brooks

Where was disease contracted if not at place of death? \_\_\_\_\_

(ADDRESS) Stratford Mo

Former or usual residence \_\_\_\_\_

Filed 3-9, 1915 Jessie Foster REGISTRAR

PLACE OF BURIAL OR REMOVAL Danforth DATE OF BURIAL March 4, 1915

UNDERTAKER Wm Whitmore ADDRESS Stratford Mo

Exact statement of OCCUPATION, as verified by supply. AGE should be properly classified.

MISSOURI SUPPLEMENTARY

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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