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 Knox

Township Ed Shelton

or

Village

or

City (NO. , St.: Ward)

Registration District No. 1029 File No. 17 37744

Primary Registration District No. 5602 Registered No. 17

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

FULL NAME Francis J. Ramier

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Apr (Month) 28 (Day), 1843 (Year)

AGE: 62 yrs. 6 mos. 16 ds.

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

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

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS

NAME OF FATHER: D J McVey

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

MAIDEN NAME OF MOTHER: Margaret E Campbell

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E Marble

(ADDRESS) Edina

Filed Dec 12, 1915 D L Howerton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 12 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch, 1915, to Oct, 1915, that I last saw her alive on Oct 9, 1915, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Disease of Heart (Mitral)

79

(Duration) yrs. 6 mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

10-12, 1915 (Address) Edina 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: Mont Canell

DATE OF BURIAL: Oct 14, 1915

UNDERTAKER: Mudd Sarver

ADDRESS: Edina Mo

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occu hospital or in give its NAME of street and nu

FULL NAME _____

Revised United States Standard Certificate

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 _____, _____
(Month) (Day)

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

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191_____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIE RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS