LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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.

1. PLACE OF DEATH
County: Cass County — Registration District No.: 149 — File No.: 4 431
Township: — Primary Registration District No.: 4083 — Registered No.: 149
City: Cleveland (No. ..., ... St. ... Ward)

2. FULL NAME: Walton Ratliff

(a) Residence. No. ... St. ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 23-1893

7. AGE: Years 27 | Months 1 | Days 7 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bank Cashier
(b) General nature of industry, business, or establishment in which employed (or employer): ...
(c) Name of employer: Farmers Bank

9. BIRTHPLACE (CITY OR TOWN): Cleveland
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Fountain Ratliff
11. BIRTHPLACE OF FATHER (CITY OR TOWN): ...
(STATE OR COUNTRY): Jacksonville Mo.
12. MAIDEN NAME OF MOTHER: Sudie Walton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): ...
(STATE OR COUNTRY): Canada

14. INFORMANT: Fountain Ratliff
(Address): Cleveland Missouri

15. FILED 2-2, 1920. W. N. Hawkins, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 19

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1920, to Jan. 31, 1920, that I last saw him alive on Jan 31, 1920, and that death occurred, on the date stated above, at 11:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
11 d
10 d
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Influenza
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED: At home
IF NOT AT PLACE OF DEATH: ...
DID AN OPERATION PRECEDE DEATH? No. DATE OF: —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ...
(Signed): J. H. Ferrel, M. D
, 19 (Address): Louisburg Kans

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Glenwood Cemetery — DATE OF BURIAL: Feb 2 1920
20. UNDERTAKER: H. F. Williams — ADDRESS: ...

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... .....St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.