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

17163

1. PLACE OF DEATH
County: Vernon — Registration District No.: 873 — File No.:
Township: Virgil — Primary Registration District No.: 6158 — Registered No.: 3
City: (No. , St. Ward)

2. FULL NAME: Eliyah Ramey
(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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): March 11 1837

7. AGE: Years 88 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DEACESED
(a) Trade, profession, or particular kind of work: Farmer (Retired 15 yrs)
(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): Ohio

PARENTS
10. NAME OF FATHER: William Ramey
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va
12. MAIDEN NAME OF MOTHER: Frances Neff
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Penn

14. INFORMANT: J. E. Ramey
(Address): Montevallo, Mo #2.

15. FILED May 4, 1925 R. S. Moffatt, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 1 1925

17. I HEREBY CERTIFY, That I attended deceased from Apr 28, 1925, to May 2, 1925, that I last saw him alive on Apr 28, 1925, and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile Gangrene
Patient was so old can
Live no
(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) W. P. Hamlin, M. D.
May 2, 1925 (Address) El Dorado Springs

*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: Virgil Cemetry — DATE OF BURIAL: 5/2 1925

20. UNDERTAKER: McGuinn & El Dorado — ADDRESS: Sprg. 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.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

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

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

City..... (No.....) ..... St. .....

2. FULL NAME .....

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

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

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)

17.
I HEREBY CERTIFY, That I attended deceased from
....., 19....., to .....
that I last saw h..... alive on....., 19.
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....

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).....

, 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE

20. UNDERTAKER	ADDRE

Revised United States Standard Certificate of Death

"Typhoid pneumonia ("Pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningeal, peritoneum* etc.