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

Do not use this space.

16911

791

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4863

City St Louis Mo. (No. Deaconess Hosp. St. ..... Ward)

2. FULL NAME Aurien Ramey

(a) Residence. No. 1605 NA 19 Sh St., 25 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) April 8th 1906.

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
21	1 Mth	14.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bank clerk

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER S. C. Ramey

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

12. MAIDEN NAME OF MOTHER Mary E. Sebastian

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

14. INFORMANT John B. Brockland
(Address) 1827 Hogan St

15. MAY 24 1927 FILED ....., 19.. Max C Starkloff REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1927

17. I HEREBY CERTIFY, That I attended deceased from 4/21 ....., 1927, to 5/23 ....., 1927 that I last saw him alive on 5/23 ....., 1927, and that death occurred, on the date stated above, at 2.15 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular Heart Disease (Mitral Insufficiency)

90a 92A 56E (duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Acute Inflammatory Rheumatism (Recurrent attacks) (duration) ..... yrs. 1 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? 1605 S No 19th St.

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination, X-ray

(Signed) A. R. Shreffler, M.D

5/23, 1927 (Address) 1021 Missouri Bldg. St Louis.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Walhala

DATE OF BURIAL May 26th 1927

20. UNDERTAKER Aug Brockland L&U Co

ADDRESS 1421 N 9 Sh

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.