

OCT 4 1927

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

Do not use this space.

26253

1. PLACE OF DEATH

County Stoddard
Township.....
City Bates (No.....) St..... Ward.....

Registration District No. 838
Primary Registration District No. 4509

File No.....
Registered No. 104

2. FULL NAME

Eve Ramsey
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25 - 1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
44 11- 2A

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

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

10. NAME OF FATHER M. J. Stull

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

12. MAIDEN NAME OF MOTHER Nancy H. Herper

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

14. INFORMANT R. E. Stull
(Address) Ferguson, Mo.

15. FILED 9-1-27 F. Labue
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1927, to Aug 19, 1927, that I last saw her alive on Aug 16, 1927, and that death occurred, on the date stated above, at (?) m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Had fracture Hip - Aug 14 - 1927
I had treated her for
Arctic Rheumatism & this
might have been cause of her
death (duration) yrs. mos. ds.

CONTRIBUTORY death - 2 1/2 hrs
(SECONDARY) (duration) 92 1/2 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? Checked - no.

WHAT TEST CONFIRMED DIAGNOSIS? Chical
(Signed) J. P. Braudon M. D.
, 19 (Address) Essay, Mo.

*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 Dexter Cemetery DATE OF BURIAL Aug 24 1927

20. UNDERTAKER C. O. Biggs ADDRESS Dexter Mo.

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.

MEMORANDUM FOR THE BOARD OF DIRECTORS
SUBJECT: [Illegible]

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[Small handwritten mark or signature]

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Stoddard
Township _____
City Dexter (No. _____)

Registration District No. 838
Primary Registration District No. 4509

File No. _____
Registered No. 104
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.

Eva Ramsey

PERSONAL AND STATISTICAL PARTICULARS

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

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) _____

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 10/12, 1927

F. LaBar
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 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:

Had fracture hips Aug 14-27
I have treated her for acute
regeneration & this might have
been cause of her death (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Automobile accident
in Dexter mo. Stoddard Co. (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL _____

19

20. UNDERTAKER _____

ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE
CERTIFICATE IS IN THEY ARE

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