

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

Do not use this space.

26922

**1. PLACE OF DEATH**

County Franklin  
Township Columbia  
City          (No.         )

Registration District No. 289  
Primary Registration District No. 5407

File No.           
Registered No. 49  
St.          Ward         

**2. FULL NAME**

Ethel Lucile Ratliff

(a) Residence No.          St.          Ward           
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

Female

**4. COLOR OR RACE**

White

**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) about Nov. 1925

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
3	8		

**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) Reynolds Co. Mo.

**10. NAME OF FATHER**

J. H. Ratliff

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Iron Co, Mo.

**12. MAIDEN NAME OF MOTHER**

Sarah Thompson

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Greenway Ark

**14.**

INFORMANT J. H. Ratliff  
(Address) Malden Mo.

**15.**

FILED 8-25-28 S. C. Mitchell  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 24 1928

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1928, to Aug 24, 1928 that I last saw h.l.a. alive on Aug 24, 1928, and that death occurred, on the date stated above, at 6:15 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Had two previous attacks one and one half years ago.

**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) H. Raymond Carlstrom M.D.

8-25-1928 (Address) Malden 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**

**DATE OF BURIAL**

Malden Mo

8-25 1928

**20. UNDERTAKER**

W. L. Craig

**ADDRESS**

Malden

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.

Patient had an attack one year six months ago

that paralyzed left arm.

one attack one year ~~three~~ <sup>three</sup> months ago that

paralyzed left leg and ~~leg~~ <sup>leg</sup> ~~and~~ <sup>and</sup> ~~leg~~ <sup>leg</sup>.

Attack Aug 24 paralyzed Right side and

never regained Consciousness. had projected vomiting

dilatation of Right pupil.

September 24, 1928.

Dr. S. E. Mitchell,  
Malden, Mo.

Dear Mr. Mitchell:-

In looking over the death certificates my attention was called to the certificate of Ethel Lucille Ratliff, who died at Malden August 24, 1928 while being attended by Graydon Carlstrom, osteopath.

This certificate gives Cerebral Hemorrhage as the cause of death, but explains how Paralysis of parts of the body occurred at different times. It is rather strange that a child of this age would die of Cerebral Hemorrhage, and will say confidentially to you that it looks like a case of Infantile Paralysis, and I request that you secure all the information possible in regard to this case.

I am enclosing a supplementary copy of the death certificate, and insist that the question, what test confirmed diagnosis, be filled out, and of course any other information that you may find.

This letter is personal and for your own information.

By direction of Dr. James Stewart, State Health Commissioner.

Sincerely yours,

R. L. Russell, M. D.,  
State Board of Health

RLR/EA

**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..... Dunklin ..... Registration District No. 289 ..... File No. ....  
Township..... Cottonhill ..... Primary Registration District No. 5407 ..... Registered No. 49 .....  
City..... (No. ....) ..... St. .... Ward)

**2. FULL NAME** Ethel Lucille Rathliff

(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)

Female | White

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) don't know - 1925

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>3</u>	<u>8</u>		

**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) Reynolds Co. Mo.

10. NAME OF FATHER J. H. Rathliff

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

12. MAIDEN NAME OF MOTHER Sarah Thompson

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

14. INFORMANT J. H. Rathliff  
(Address) Malden Mo.

15. FILED 8-25 1928 R. E. Mitchell  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 24 1928

17. I HEREBY CERTIFY That I attended deceased from July 8, 1928, to Aug 24, 1928  
(that I last saw her... alive on) Aug 24, 1928, and that death occurred, on the date stated above, at 6:15 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage

(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) Had two previous attacks one and one half years ago  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH: .....

DID AN OPERATION PRECEDE DEATH? 44 DATE OF Aug

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?

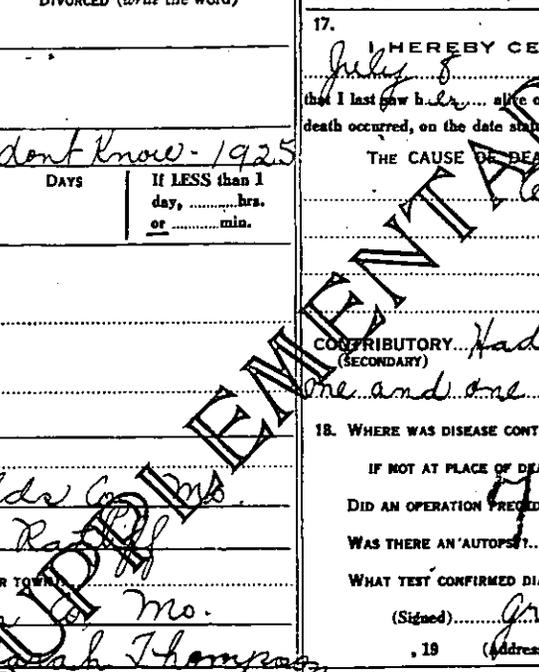
(Signed) Graydon Carleton, D.O.  
.19 (Address) Malden

\*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 Malden, Mo. DATE OF BURIAL 8-25 1928

20. UNDERTAKER W. L. Craig ADDRESS Malden

N. Every item of information should be carefully applied. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW



Patient had an attack one year six months ago that paralyzed left arm.

one attack one year three months ago that paralyzed left leg and left shoulder.

attack Aug. 24 ~~was~~ paralyzed right side and never regained consciousness. Had projectile vomiting-dilatation of right pupil.

17

5-26922