

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

Do not use this space.

38547

**1. PLACE OF DEATH**

County.....  
Towship.....  
City St. Louis

Registration District No. 791  
Primary Registration District No. 1003

File No.....  
Registered No. 10943  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. City Hosp. St. Louis, Mo. War 23  
(Usual place of abode)  
Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

Clyde Chisholm Ratcliff, M.D.  
City Hosp. St. Louis, Mo. War 23  
McComb, Miss.  
(If nonresident, give city or town and State)

**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) 12-10-1904

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
24 10 28

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

9. BIRTHPLACE (CITY OR TOWN) Alburn,  
(STATE OR COUNTRY) Miss.

10. NAME OF FATHER M.D. Ratcliff, M.D.

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

12. MAIDEN NAME OF MOTHER Ola Chisholm,

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

14. INFORMANT M. D. Ratcliff, M.D.  
(Address) McComb, Miss.

15. FILED NOV - 9 1929 Max C. Stander  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 8, 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1929, to Nov. 8, 1929 that I last saw h.i.m. alive on Nov. 8, 1929, and that death occurred, on the date stated above, at 4:20 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Bilateral Lobar  
Pneumonia  
108

(duration) yrs. mos. 7 ds.

CONTRIBUTOR (SECONDARY) 1010  
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Clinical, Laboratory, Xray  
(Signed) Carl W. Holt, M. D.  
11/8, 1929 (Address) City Hospital, St. Louis,

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL McComb Miss DATE OF BURIAL Nov. 8 1929

20. UNDERTAKER H. Rindskopf ADDRESS 5216 Belmont

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.

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2/3  
2

