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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County: Greene — Registration District No.: D Lee Cox 318 — File No.: 8362

Township: — Primary Registration District No.: 2001 — Registered No.: 208

City: Springfield (No. 1824 College St. Ward)

2. FULL NAME Irwin Riddle Ralston

(a) Residence. No. Zelienople Penn. 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)
m	w	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27-1893

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	36	7	9	

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): Penn.

PARENTS

10. NAME OF FATHER: J. H. Ralston

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

12. MAIDEN NAME OF MOTHER: Theodosia Thayer

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

14. INFORMANT: Mrs. J. H. Ralston (Address) Zelienople Penn.

15. FILED 3-10, 1930 Lon Sharp, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-6-1930

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to 3-6-1930, that I last saw him alive on 3-6-1930, and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of Lungs

23A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

31

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

3/8 (Signed) Lee Cox, M. D. 1930 (Address) Springfield 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: Natl. Cemetery — DATE OF BURIAL: 3-13 1930

20. UNDERTAKER: W. Harvey — ADDRESS: Mount Marker