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.

REC'D AUG 12 1939

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

27033
Do not use this space.

1. PLACE OF DEATH
(a) County Stone 2 Registration District No. 845
(b) Township Ruth Primary Registration District No. 6108 Registered No.
(c) City ~~Reeds Springs~~ (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 2 yrs. mos. ds. (f) How long in U. S., if of foreign birth? 2 yrs. mos. ds.

2. PRINT FULL NAME 423 Juanita Rhea Ralston
(a) Residence, No. Reeds Springs Mo St.
(Usual place of abode, if no street address, write county or city) (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): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 27 - 1937
7. AGE: YEARS 2 MONTHS 3 DAYS 27 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Reed Springs Mo.

FATHER
13. NAME Albert Ralston
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stone Co.

MOTHER
15. MAIDEN NAME Olive Craig
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greene Co.

17. INFORMANT (ADDRESS) Albert Ralston Reeds Springs
18. BURIAL, CREMATION, OR REMOVAL
PLACE Eisenhour DATE July 12 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Horine - Culver Cassville Mo
20. FILED 7/11/1939 L S Shumate
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1 1939
22. I HEREBY CERTIFY, That I attended deceased from July 1, 1939, to July 11, 1939
I last saw her alive on July 3, 1939. Death is said to have occurred on the date stated above, at 1:00 A.m.
The principal cause of death and related causes of importance were as follows:

Collegmed R. Lung.
Bronchial Pneumonia

Date of onset

Other contributory causes of importance: 1076

Name of operation no Date of
What test confirmed diagnosis? Et Ray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) J. Byaung, M. D.
763 (Address) Gama Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 839-1216
Date Filed AUG 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ...

....., or by .....,

Registered Apprentice No....., working under my personal supervision.

Signed B. E. Culver

Licensed Embalmer No. 3584

P. O. Address Caruthersville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.