

77 leaf

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

39022  
Do not use this space.

DEC 11 1939

1. PLACE OF DEATH  
 (a) County Buchanan Registration District No. 35  
 (b) Township St. Joseph Primary Registration District No. 100 Registered No. 1155  
 (c) City St. Joseph (d) Street No. St. Joseph Hospital 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 yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT-FULL NAME Bertha Luella Ratchiff  
 (a) Residence, No. Agency, Mo. St. Agency, Mo.  
 (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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 20, 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ..... hrs. or ..... min.
	<u>77</u>	<u>10</u>	<u>18</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife  
 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

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rochester New York  
 13. NAME Edwin Hunt  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) don't know

MOTHER  
 15. MAIDEN NAME Sarah Cornell  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) don't know

17. INFORMANT Ben Ratchiff  
 (ADDRESS) Agency, Mo.

18. BURIAL, CREMATION, OR REMOVAL Agency, Mo.  
 PLACE Agency, Mo. DATE Nov 9, 1939

19. FUNERAL DIRECTOR (NAME) W. A. Sullivan  
 (ADDRESS) Agency, Mo.

20. FILED Nov 8, 39 H. H. Mottelbush  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1939 to Nov 8, 1939  
 I last saw Nov 7, 1939 alive on Nov 7, 1939 Death is said to have occurred on the date stated above, at 12:35 m.  
 The principal cause of death and related causes of importance were as follows:  
Yastria hemorrhage  
hardish epilepsy  
arterio sclerosis  
 Date of onset 11-2-39  
just 3?  
subdural

Other contributory causes of importance:

Name of operation none Date of no  
 What test confirmed diagnosis? thromb 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 an way related to occupation of deceased? no  
 If so, specify  
 (Signed) W. A. Sullivan, M. D.  
 (Address) Agency, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 impor

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**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 ML

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

Signed H. A. Sullivan

Licensed Embalmer No. 1728

P. O. Address Genoa, 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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

39022  
Do not use this space.

1. PLACE OF DEATH

(a) County Douglas Registration District No. 85  
 (b) Township ..... Primary Registration District No. 1001 Registered No. 1155-  
 (c) City St Joseph (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 ..... (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Bertha Luella Ratcliff

(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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.  
77 10 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 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)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 8 1939 A. H. Henshaw Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 8 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to ....., 19..

I last saw him ..... alive on ....., 19.. Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Gastric Hemorrhage  
Cerebral apoplexy  
Deterioration  
 Other contributory causes of importance: gfr

I do not know the cause of the gastric hemorrhage.

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....

If so, specify .....

(Signed) John F. Byrnes, M. D.

(Address) St Joseph Mo

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

