

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1121

1121
106

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson 3
 (b) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
315 S Quincy
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 33 years
 years, months or days)

8. (a) PRINT FULL NAME Wm. A. Ralph H 10
 8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive 78 years
 7. Birth date of deceased Aug. 25th, 1859
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 4 10 hr. min.

9. Birthplace Indiana
 (City, town, or county) (State or foreign country)

10. Usual occupation Machinist

11. Industry or business Mo. Pac. R.R. Co.

MOTHER FATHER
 { 12. Name Daniel Ralph /
 18. Birthplace Indiana /
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Harter /
 15. Birthplace Indiana /
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elizabeth Ralph
 (b) Address 1808 E 7th St. K.C. Mo.
 17. (a) Burial (b) Date thereof Jan. 8-10
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt Hope Cemetery K.C. Mo.
 18. (a) Signature of funeral director C.H. Blackman & Son, Inc.
 (b) Address 2825 Indep. Blvd. K.C. Mo.
 19. (a) Jan 8, 1940 (b) M.M. Craue
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

0
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1808 East 7th St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 5th
 year 1940 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from
12/31, 1939 to 1-5-, 1940
 that I last saw him alive on 1-5-, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 5 days
causing acute interstitial nephritis
 Due to _____
 Due to _____

Other conditions + J.R.
 (Include pregnancy within 3 months of death)

Major findings: ✓
 Of operations _____

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ✓
 (b) Date of occurrence h
 (c) Where did injury occur? h (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature D.P. Russell (M. D. or other) _____
 Address 7231 E. 11 St. Date signed _____

Dr Russell

30 Indep. Ave.

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 _____

W. D. Blackman

Licensed Embalmer No. _____

2639

P. O. Address _____

K. C. Ins.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1121
Registrar's No. 106

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 345 1/2 Dursey (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage
Due to: Acute Interstitial nephritis
Due to: Chronic case
Other conditions: (121)
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

3. (a) PRINT FULL NAME Tom G. Ralph
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: 80 Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) 1/8/40 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No.....

P. O. Address.....

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.