

S. No. 2
-11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27508**
Registrar's No. **3141**

SEP 5 1940 399
Registration District No.

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4049 Baltimore Avenue 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 34 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 4049 Baltimore
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Mrs. May E. Ramsey 570

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John C. Ramsey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 4, 1859
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 8 0 hr. min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER

12. Name Chauncey Harris

13. Birthplace Penn.
(City, town, or county) (State or foreign country)

14. Maiden name Saffronia Mc Kay
(City, town, or county) (State or foreign country)

15. Birthplace New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. C. W. Saunders

(b) Address 4049 Baltimore Avenue

17. (a) Removal (b) Date thereof 8-6-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Girard, Kansas

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) August 6, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day Fourth
year 1940 hour Midnight minute Midnight

21. I hereby certify that I attended the deceased from _____, 1930, to August 4th, 1940
that I last saw him alive on May 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to _____
Due to _____

Other conditions Atherosclerosis, Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings: Of operations None
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(b) Date of occurrence None
(c) Where did injury occur? (City or town) (County) (State) None
(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

While at work? None (Specify type of place) (c) Means of injury: None
23. Signature M. M. Brown (M. D. or other) None
Address 210 Argyle Bldg. Date signed 8/5/40

Duration Midnight
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 *Clarence W. Chiles*.....

Licensed Embalmer No. *3473*.....

P.O. Address *76 e 700*.....

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.