

No. 94
5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 16

FILED OCT 20 1942
Registration District No. 342

Primary Registration District No. 6153

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bell City, Mo., Route 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None Ribo 1, s. p.
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED: 103

(a) State Missouri (b) County Stoddard.

(c) City or town Bell City, Route # 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME MELVIN L. RAMSEY

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

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

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

7. Birth date of deceased December 12, 1934
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

7	8	2	hr. min.
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9. Birthplace Charter Oak, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER

12. Name Jack Ramsey

13. Birthplace Vincennes, Ind. Rural
(City, town, or county) (State or foreign country)

14. Maiden name Edith Burkhart

15. Birthplace Marquand, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Jack Ramsey

(b) Address Bell City, Mo., Route 1

17. (a) Burial (b) Date thereof Aug. 15, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gravel Hill Cemetery

18. (a) Signature of funeral director Chiles Funeral Home

(b) Address Bloomfield, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14th.
year 1942 hour 5:00 minute 30 A.M.

21. I hereby certify that I attended the deceased from Aug. 5
1942 to Aug 14 1942

that I last saw him alive on Aug 19 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Pericarditis Malarial

Due to _____

Due to 28

Other conditions inherited from birth
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____
Of operations _____
Of autopsy _____

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 C. E. Lewis (M. D. or other) _____
Address Bell City, Mo Date signed 8/15/42

RECEIVED

District Health Office No.

District File Number 1042-13

Date Filed 10-15-42

Handwritten notes:
10/15/42
Howard A. Cooper
Bloomfield, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~XXXXXXXXXXXX~~

Body was not Embalmed.

Registered Apprentice No.

working under my personal supervision.

Signed Howard A. Cooper

Licensed Embalmer No. 3996

P. O. Address Bloomfield, 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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 35-023
Registrar's No. 16

FILED DEC 18 1942

Registration District No. 342

Primary Registration District No. 610-3

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

1. PLACE OF DEATH: Stoddard
 (a) County.....
 (b) City or town..... Road
 (c) Name of hospital or institution.....
 (If outside city or town limits, write "RURAL" and name of township)
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community.....
 years, months or days) (Specify whether

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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Melvin L. Ramsey
 3. (b) If veteran, name war..... 3. (c) Social Security No. 5

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month..... Day.....
 year..... hour..... minute..... M.
 21. I hereby certify that I attended the deceased from.....
 that I have seen him..... live on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

4. Sex..... m 5. Color or race..... w 6. (a) Single, widowed, married, divorced..... s
 6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased..... Dec 12 1942
 (Month) (Day) (Year)

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations.....
 Of autopsy.....

8. AGE: Years 7 Months 8 Days 11 (If less than one day) min.
 9. Birthplace..... mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation.....
 11. Industry of business.....

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

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

18. (a) Signature of funeral director.....
 (b) Address.....
 19. (a) Sept 28 1942 (b) M. B. Thrauer
 (Date received local registrar) (Registrar's signature)

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.....

SUPPLEMENTARY

35023

RECEIVED

District Health Office No. 2,

District File Number _____

Date Filed _____