

FILED SEP 5 1944

Registration District No. 329

Primary Registration District No. 4485

Registrar's No. 41

1. PLACE OF DEATH:

(a) County SCOTT
(b) City or town FARMERS MO.
(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 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County SCOTT
(c) City or town ILLMO MO
(d) Street No.
(e) Citizen of foreign country? NO
If yes, name country

3. (a) PRINT FULL NAME ALBERT RAMSEY

3. (b) If veteran, name war
3. (c) Social Security No. 344-01-1145

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWER

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

7. Birth date of deceased SEPT. 4 1882
(Month) (Day) (Year)

8. AGE: Years 61 Months 11 Days 25
If less than one day hr. min.

9. Birthplace SAPE Co. MO.
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business

MOTHER FATHER { 12. Name BENJAMIN RAMSEY
13. Birthplace BOLLINGER CO MO
14. Maiden name MARY JANE GREEN
15. Birthplace NASHVILLE TENN

16. (a) Informant MRS ALMA McCORMICK
(b) Address ILLMO, MO.

17. (a) BURIAL (b) Date thereof 7 31 44
(c) Place: burial or cremation. COMMERCE MO.

18. (a) Signature of funeral director BISPLINGHOFF-HUBBARD
(b) Address ILLMO, MO.

19. (a) Aug-4-44 (b) Mrs W. S. Tomblinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29
year 1944 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 2 1944 to July 28 1944
that I last saw him alive on July 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Respiratory failure

Due to Bronchial pneumonia 2 days
(terminal)

Due to Pulmonary tuberculosis years
Other (include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
13 pl

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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature Benton J. Wilson (M. D. or other) DO.
Address Farmers, Mo. Date signed July 31, 1944

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

RECEIVED

District Health Office No. 2,

District File Number 84-1175

Date Filed 8-30-44

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.