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ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1945

Registration District No. 299

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6028

State File No. 3188

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds

(b) City or town Rural #32-Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Lesterville Twp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 73 years. 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Reynolds

(c) City or town Rural #32-Township .90
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Anderson Ratliff

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M D

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 9 (Day) 1871 (Year)

8. AGE: Years 73 Months 8 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Reynolds (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name James Ratliff
13. Birthplace Reynolds, County Mo 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Jane Johnson
15. Birthplace Mo 0 (City, town, or county) (State or foreign country)

16. (a) Informant Tom Ratliff
(b) Address Greely, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-45 (Month) (Day) (Year)
(c) Place: burial or cremation Greely, Mo.

18. (a) Signature of funeral director Hobart Grantham
(b) Address Salem, Mo.

19. (a) Feb 6th 1945 (Date received local registrar) (b) Mae Jones Wallington (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29 — 1945
year ..... hour 5 minute 0 P M.

21. I hereby certify that I attended the deceased from January 20, 1945, to January 29, 1945, that I last saw him alive on January 20, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Parenchymatous Nephritis
Coronary Thrombosis

Due to

Due to

Other conditions ✓
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) no

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

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

While at work? no (e) Means of injury —

23. Signature J. R. Pyrtle (M. D. or other)

Address Centerville Date signed 1/29-45

1194

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 24567
Date Filed 2-8-45

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 me, Registered Apprentice No.

working under my personal supervision.

Signed Oscar E. Lichliter

Licensed Embalmer No. 3546

P. O. Address Lt James M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.