

FILED FEB 20 1947

State File No. _____

Registration District No. 160

Primary Registration District No. 3029

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Crystal City
(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 1
In this community 58 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson
(c) City or town Crystal City
(If outside city or town limits, write "RURAL")
(d) Street No. 100 Virginia Area
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Ramey

3. (b) If veteran, name war ✓ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 2, 1881
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 9 27 hr. min.

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

10. Usual occupation Retired

11. Industry or business laborer

12. Name Ernest J. Ramey

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

14. Maiden name unknown

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

16. (a) Informant Mrs. Clarence Chernath

(b) Address Crystal City, Mo.

17. (a) Burial (b) Date thereof Feb. 2, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crystal City, Mo.

18. (a) Signature of funeral director Geoffrey P. Palitta

(b) Address Crystal City, Mo.

19. (a) Feb. 6, 1947 (b) Alvin Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31
year 1947 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan. 13
1947, to Jan. 31, 1947
that I last saw him alive on Jan. 30, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 6-8 hrs.

Due to Unknown

Due to _____

Other conditions Tertiary Lucs About 30 yrs.
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 B. H. D. [Signature] (M. D. or other)
Address Crystal City, Mo. Date signed 2-1-47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 2-13-47

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 Gentry R. Polittle
Licensed Embalmer No. 3481
P. O. Address Crystal City

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.

Registration District No. 160

Primary Registration District No. 3029

1. PLACE OF DEATH:

(a) County Jefferson
(b) City or town Crystal City
(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 _____ (Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME George Ramey
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Ramey 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 2 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1947 (hour) _____ minute _____ M.

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

Due to _____
Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) _____
Date signed _____

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

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

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

S-6254