

No. 2  
12-45  
3-17-39  
1/247070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED MAR 21 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. **7890**

Registration District No. **37**

Primary Registration District No. **4049**

Registrar's No. **8**

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

2. USUAL RESIDENCE OF DECEASED:  
(a) State **mo** (b) County **Boone** **10**  
(c) City or town **centralia** **0**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) **0**  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Sudie J. Ratliff**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced. **W 2**  
6. (b) Name of husband or wife **J. W. Ratliff** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **AVA** **16** **1861**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**85** **6** **20** hr. min.

9. Birthplace **Bethel** **Ky** **1**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name **Augusta Batts**  
13. Birthplace **Ky** **1**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown** **9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bob Fagg - Daughter**  
(b) Address **Centralia**

17. (a) **Burial** (b) Date thereof **March 2, '47**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Centralia**

18. (a) Signature of funeral director **Wm. Vermigan**  
(b) Address **Centralia Mo**

19. (a) **Mar. 12-1947** (b) **Maud McBride**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **5<sup>th</sup>**  
year **1947** hour **9** minute **30 P.** M.  
21. I hereby certify that I attended the deceased from **July 1, 1943**  
\_\_\_\_\_, 19\_\_\_\_, to **3-5-47**, 19\_\_\_\_;

that I last saw her alive on **2-25-47**, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**  
Duration \_\_\_\_\_

Due to **Broken Hip and**  
**Infirmity of old age.**  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy **186A** **14**  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
Underline the cause to which death should be ascribed statistically.

22. If death was due to external causes, fill in the following:  
(c) Accident, suicide, or homicide (specify) \_\_\_\_\_ **10**  
(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)  
(c) Means of injury \_\_\_\_\_

23. Signature **P. Baker** (M.D. or other) **2**  
Address **Centralia Missouri** Date signed **3-8-47**

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

RECEIVED  
District Health Officer No. 9,  
District File Number 3-20-47  
Date Filed \_\_\_\_\_

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 Grover Ferguson  
Licensed Embalmer No. 4270  
P. O. Address Centralia, 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.

Registration District No. 37

Primary Registration District No. 4049

1. PLACE OF DEATH:  
(a) County Boone  
(b) City or town Centralia  
(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 (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Sudie J. Ratliff  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced und

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

7. Birth date of deceased Aug 16 1886  
(Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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. (c) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

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 \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and 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) accident

(b) Date of occurrence July 18, 1947

(c) Where did injury occur? Centralia Boone Mo. (City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury slipped on floor

23. Signature P. B. Baker (M. D. or other) \_\_\_\_\_

Address 4-15-47 Centralia Boone Mo.

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

SUPPLEMENTAL

S-7890