

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17577  
Registrar's No. 2095

FILED MAY 26 1947  
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K.C. Mo

(c) Name of hospital or institution: St. Mary's Hosp  
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 22 days  
(If not in hospital or institution, write street number or location)

In this community 22 days (Specify whether years, months or days) 15 hrs 50 min

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson

(c) City or town K.C.  
(If outside city or town limits, write "RURAL")

(d) Street No. 2120 Madison  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Elizabeth Ramirez

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F 5. Color or race Mex

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 4-19-1947  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 11  
year 1947 hour 10 minute 33 P. M.

21. I hereby certify that I attended the deceased from 4-19- 1947 to 5-11- 1947  
that I last saw her alive on 5-11- 1947  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>-</u>	<u>-</u>	<u>22</u>	<u>15</u> hr. <u>50</u> min.

Immediate cause of death Acute Circulatory failure

Due to Congenital malformations

Due to \_\_\_\_\_

9. Birthplace K.C. Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation new born

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

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

Duration \_\_\_\_\_

MOTHER, FATHER

12. Name José Carmen Ramirez

13. Birthplace Salamanca Mex  
(City, town, or county) (State or foreign country)

14. Maiden name Rachel Hernandez

15. Birthplace K.C. Mo  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: 157 mm  
Of operations \_\_\_\_\_

Of autopsy As above

16. (a) Informant mother

(b) Address 2120 Madison St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-12-47  
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's

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? \_\_\_\_\_

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

(b) Address K.C. Mo

19. (a) 5-12-47 (Date received local registrar)

(b) Deraldine Holmes (Registrar's signature)

23. Signature Richard Ramirez (M.D. or other) \_\_\_\_\_

Address 1405 Broadway Date signed 5/17/47

**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 Blaine E. Weiler

Licensed Embalmer No. 4075

P. O. Address K.C. 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.**