

FILED JAN 6 1949

STANDARD CERTIFICATE OF DEATH

State File No. **39674**
Registrar's No. **288**

BIRTH NO. _____ REG. DIST. NO. **77** PRIMARY REG. DIST. NO. **3016**

1. PLACE OF DEATH a. COUNTY Cole		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cole	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jefferson City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 703 W. High	
3. NAME OF DECEASED a. (First) Grant (Middle) - (Last) Ramsey			4. DATE OF DEATH (Month) (Day) (Year) Dec 24 1948
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman	11. BIRTHPLACE (State or foreign country) Jefferson City
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Joe Edwards 1114 1/2
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. a b d		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Decompensated Heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arterio Sclerosis DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 21 1948 to Dec 24 1948 that I last saw the deceased alive on Dec 24 1948 and that death occurred at 7:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. Bruns (Degree or title)		23b. ADDRESS 239 Madison	23c. DATE SIGNED Dec 27 1948
24a. BURIAL CREMATION/REMOVAL (Specify)	24b. DATE 12-27-48	24c. NAME OF CEMETERY OR CREMATOR Springfield	24d. LOCATION (City, town, or county) (State) Cole County, Mo
DATE REC'D BY LOCAL REG. 1-17-49	REGISTRAR'S SIGNATURE V.R. P. Donis	FUNERAL DIRECTOR'S SIGNATURE Tanner Serv. 700 Jeff. City	ADDRESS

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

26-49

Bume

RECEIVED
District Health Officer No. 9,
District File Number
JAN 5 1949
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

Donald Freeman

Student Embalmer No. *281*

working under my personal supervision.

Student
Student Embalmer

Signed *J. W. Anderson*

Licensed Embalmer No. *3641*

P. O. Address *Jms*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 1000Registration District No. 77Primary Registration District No. 3016Registrar's No. 288

1. PLACE OF DEATH:

- (a) County Jefferson
 (b) City or town Jefferson 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 Gant Ramsey

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

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

7. Birth date of deceased
- week
- (Month) (Day) (Year)

8. AGE:
- all 74
- Years Months Day If less than one day hr. min.

9. Birthplace
- mo.
- (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 _____
-
- (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a)
- 1-17-49
- (b)
- R. P. Davis MD
-
- (Date received local registrar) (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 _____ Day _____
-
- year
- 1948
- 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(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 J. G. Bruce (M. D. or other) _____Address Jefferson City, Mo. Date signed 1-14-49

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

S-39674