

FILED JUN 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15043

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>44</u>		PRIMARY REG. DIST. NO. <u>4060</u>		Registrar's No. <u>22</u>		
1. PLACE OF DEATH a. COUNTY <u>CALDWELL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>CALDWELL</u> / <u>13</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BRECKENRIDGE</u>		c. LENGTH OF STAY (in this place) <u>5 MO.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BRECKENRIDGE</u> / <u>0</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MRS. JOHN SOUDERS NURSING HOME</u>				d. STREET ADDRESS (If rural, give location) <u>HOME</u> / <u>2</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANSON</u> b. (Middle) <u>CLAUDE</u> c. (Last) <u>RAMSEY</u>			4. DATE OF DEATH (Month) (Day) ((Year) <u>5/12/1949</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>AUG. 20 1884</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>13</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>CALDWELL CO. ? MO. ( )</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>MEREDITH W. RAMSEY</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH J. KISSINGER</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. JOHN SOUDERS</u>		ADDRESS <u>BRECKENRIDGE</u>		
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 Days</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis, hypertension, hypertrophied heart</u>			Interval <u>not stated</u>	
				DUE TO (c) _____				
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>243X</u>	
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)		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 <u>May 4, 1949</u> , to <u>May 13, 1949</u> , that I last saw the deceased alive on <u>May 13, 1949</u> , and that death occurred at <u>6 P. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>J. W. Webb M.D.</u> (Degree or title)				23b. ADDRESS <u>Breckenridge Mo</u>		23c. DATE SIGNED <u>5-16-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5/15/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>BRECKENRIDGE, MO.</u>		
DATE REC'D BY LOCAL REG. <u>6-3-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nell B. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gene C. Michal</u>		ADDRESS <u>BRAYMER MO</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

**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 \_\_\_\_\_

~~Student Embalmer No.~~

~~working under my personal supervision.~~

Signed \_\_\_\_\_

*Gene C. Michael*

~~Signed \_\_\_\_\_~~

~~Student Embalmer~~

Licensed Embalmer No. 4340

P. O. Address Braymor, 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.