

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28066

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7008

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>2734 Thomas</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) <u>Adam</u>		b. (Middle) <u>NNN</u>	
c. (Last) <u>Ratliff</u>		(Month) (Day) (Year) <u>Aug. 6, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (in years last birthday) <u>abt 38</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Newport, Ark.</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Jordan Ratliff</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Earnestine Ratliff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Earnestine Ratliff</u>		ADDRESS <u>2734 Thomas</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 <u>1561</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>June 29</u> , 19 <u>55</u> , to <u>August 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>August 6</u> , 19 <u>55</u> , and that death occurred at <u>10:35P</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>C. J. Perillia, M.D.</u>		23b. ADDRESS <u>BARNES HOSPITAL</u>	
23c. DATE SIGNED <u>8/6/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>8/12/55</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Marianna,</u>		24d. LOCATION (City, town, or county) (State) <u>Arkansas</u>	
DATE REC'D BY LOCAL REG. <u>AUG 11 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Wade Granberry</u>		ADDRESS <u>4202 Finney</u>	

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

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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..

Student.....  
Signature of Student Embalmer

Signed *James T. Carter*.....

Licensed Embalmer No.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.