

Health, Welfare, Public Service

300-56

Use only standard nomenclature in Part 10. No symptoms will be listed. All diseases in Part 1 must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 26 1957

34017

STATE FILE NUMBER

318

1003

8674

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Venice</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Infirmary</u>				Length of stay in 1b <u>5 days</u>		d. STREET ADDRESS (If outside, give location) <u>32 313 Slough Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Alex</u> Middle <u></u> Last <u>Ratliff</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>14</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14, 1887</u>			
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		9. AGE (In years last birthday) <u>70</u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Webster County, Miss.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>Thomas Ratliff</u>					
14. MOTHER'S MAIDEN NAME <u>Mary Timkens</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 <u>Mary Lee James Venice, Ill.</u> Address <u>313 Slough Rd</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage (C.V.A.)</u> <u>Cerebral hemorrhage</u> <u>Essential Hypertension</u> DUE TO (b) <u>essential hypertension</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Lobar Pneumonia</u> <u>Lobar pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>E. St. Louis St. Clair, Ill</u>			
21. I attended the deceased from <u>9/10/57</u> to <u>9/14/57</u> and last saw ^{her} him alive on <u>9/14/57</u> Death occurred at <u>9:20 A.M. 9th</u> on the date stated above; and to the best of my knowledge, from the causes stated.				22a. SIGNATURE <u>William T. Queno M.D.</u> (Degree or title) <u>M.D.</u>				22b. ADDRESS <u>1228 Piggott</u>	
22c. DATE SIGNED <u>9/16/57</u>				23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Garden of Memory - Huekey Township, Ill.</u>				23d. LOCATION (City, town, or county) <u></u> (State) <u></u>				24. FUNERAL DIRECTOR <u>Marion's Office</u> Address <u>2114 Mo. Ave</u>	
25. DATE RECD. BY LOCAL REG. <u>SEP 16 57</u>				26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>					

(Licensed Embalmer's Statement on Reverse Side)

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 *Ben H. Baldwin*

Licensed Embalmer No. *247*

P. O. Address *7217 26*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.