

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020062
STATE FILE NUMBER

FILED MAY 23 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4462

300
-57

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Texas			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN 31 Houston 1070		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 Barnes Hospital 0			Length of stay in 1b			d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle M. Last Ratterree				4. DATE OF DEATH Month April Day 23 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 19, 1940		9. AGE (In years to birthday) 18 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student Nurse			10b. KIND OF BUSINESS OR INDUSTRY Barnes Hospital		11. BIRTHPLACE (City and state or country) Norwood, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Clyde Ratterree			13b. MOTHER'S MAIDEN NAME Fern Owens			14. NAME OF HUSBAND OR WIFE None	
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. Unknown		17. INFORMANT Address Clyde Ratterree, Houston, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Internal Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 299x						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. If per nature of injury in PART I or PART II, in 18b Open wound to acute abdomen					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) aplasia due to suspected toxic agent. Exact time, place, and type could not be determined					
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		COUNTY STATE	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) James M Kelly Deputy				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 4-24-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-24-58		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Houston, Mo.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. APR 24 '58		26. REGISTRAR'S SIGNATURE Paul Smith	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

8961 0 6 709

38282

notarion

atwood, J.

Interment

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certified

state

of the State of

Illinois

1958

of the State of

Illinois

Illinois

8961 0 6 709

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atwood, J.

Interment

certified

state

Illinois

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 *Chas. P. Padwick*

Licensed Embalmer No. *7077*

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.