

Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002420

STATE FILE NUMBER

Registration District No. 276 Primary Registration District No. 5947 Registrar's No. 76

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>On 14th St. E. Eureka, East on 14th St. E. Prof. Thea Ma</u> | | c. CITY OR TOWN <u>Washington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print) First: <u>MARK</u> Middle: <u>ALLEN</u> Last: <u>RANSOM</u> | | | 4. DATE OF DEATH Month: <u>2/</u> Day: <u>2/</u> Year: <u>59</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/2/59</u> | | 9. AGE (In years last birthday) <u>0</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>8</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Sullivan, Missouri</u> | | |
| 10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <u>JULE RAMOND RANSOM</u> | | 13b. MOTHER'S MAIDEN NAME <u>JANIE ELLEN WEST</u> | | 14. NAME OF HUSBAND OR WIFE <u>Infant</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>None</u> | | 17. INFORMANT Address <u>Jule Ramond Ransom,</u> | |

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|--|--|--|--|--|--|
| 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>Encephalopathy due to Anoxia.</u> DUE TO (b) <u>Strangulation of Umbilical Cord during Labor.</u> DUE TO (c) <u>Labor.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7610</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |

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|---|--|---|---|--|--|
| 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 _____ a.m. _____ p.m. | | | 20d. INJURY OCCURRED WHILE AT <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 2/2/59 to _____ and last saw him alive on 2/2/59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

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|--|--|--------------------------------------|--|--|--|
| 22a. SIGNATURE (Degree or title) <u>Ronald J. Att. to 2</u> | | 22b. ADDRESS <u>Sullivan, Mo.</u> | | 22c. DATE SIGNED <u>2/2/59</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>2-4-1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cross Road Cemetery</u> | |
| | | | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | |

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|--|--|-----------------------------|--|--|--|
| 24. FUNERAL DIRECTOR <u>R. D. [Signature]</u> | | ADDRESS <u>Cuba, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-7-59</u> | |
| | | | | 26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

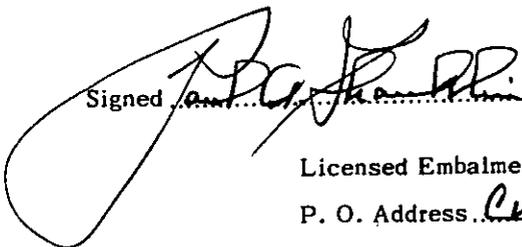
All diseases in Part I must be causally related.

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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 ,
Licensed Embalmer No. 3472,
P. O. Address Cuba, Ma.

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.