Health, Welfare Public Service

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1-57

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I

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003412
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 277

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION St.Louis Children's — Length of stay in Hospital 23days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY
c. CITY OR TOWN Mount Vernon — Inside Limits Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) 17 Rushton Drive — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First: Kurt Middle: Anthony Last: Ranmar

4. DATE OF DEATH Month: Jan Day: 8 Year: 1959

5. SEX: Male 0

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] 0 DIVORCED [ ]

8. DATE OF BIRTH: Nov.26, 1958

9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days 23da; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): St.Louis Missouri 0

12. CITIZEN OF WHAT COUNTRY? U.S. A

13a. FATHER'S NAME: James Paul Ranmar

13b. MOTHER'S MAIDEN NAME: Norma Bishop

14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Jane Henrichsen Address: 500 S.Kingshighway

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Meningomyelocele

DUE TO (c) Arnold-Chiari Malformation 753.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Hydrocephalus

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ] /

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 12-16-58, to 1-8-59 and last saw her/him alive on 1-8-59. Death occurred at 7:10pm on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Leonard Peter Rome (Degree or title) M.D. 0

22b. ADDRESS 500 S.Kingshighway

22c. DATE SIGNED 1-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 1-9-59

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Mt.Vernon,Ill.

24. FUNERAL DIRECTOR Pulley Funeral Home, ADDRESS Mt.Vernon,Ill.

25. DATE RECD. BY LOCAL REG. JAN 9 '59

26. REGISTRAR'S SIGNATURE Earl Smith MD
MXB

(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 ..... No Embalm .....

Licensed Embalmer No.....

P. O. Address.....

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.