

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024427

FILED VS AUG 10 1959

Registration District No. 55 Primary Registration District No. 3011 Registrar's No. 60 STATE FILE NUMBER

INDEXED

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|---|-------------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carrollton</u> Length of stay in 1b <u>14 hours</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bales Hosp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN <u>Carrollton</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>R.R. 2#</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED First <u>Clyde</u> Middle <u>Wilbur</u> Last <u>Ramsey</u> | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>8</u> Year <u>1959</u> | | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-2-1903</u> | 9. AGE (last birthday) <u>55</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (City and state or country) <u>Hale, Mo.</u> | | | |
| 10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | | 10d. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>Enoch Ramsey</u> | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Besse Ramsey</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>494-12-8906</u> | | 17. INFORMANT Address <u>Mrs. Clyde Ramsey Carrollton Mo</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>CONGESTIVE HEART FAILURE (Myocardial insufficiency)</u> DUE TO (b) <u>Previous infection of sinuses 6 months, bladder kidney infection cystitis, anuria from kidney failure vascular disease Endarteritis--resulting in hemorrhage and detached retina</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>6 mos</u> <u>8 mos</u> <u>3 day</u> <u>3 months</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>food poisoning incurred on August 5th (peanuts)</u> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <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. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | | |
| 20f. CITY, TOWN, OR LOCATION _____ | | 20g. COUNTY _____ | | 20h. STATE _____ | | | |
| 21. I attended the deceased from <u>8-5-59</u> to <u>8-8-59</u> and last saw her/him alive on <u>8-8-59</u> Death occurred at <u>3 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22. SIGNATURE (Degree or title) <u>Regent L. L. Smith</u> | | | | 22b. ADDRESS <u>Carrollton, Mo.</u> | | | |
| 22c. DATE SIGNED <u>8-15-59</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8/10/59</u> | | 23c. NAME OF CEMETERY OR CREMATORIUM <u>Oak Hill Cemetery</u> | | | |
| 23d. LOCATION (City, town, or county) (State) <u>Carrollton, Mo.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Marshall Funeral Home Carrollton</u> | | | 25. DATE RECD. BY LOCAL REG. <u>8-8-59</u> | | 26. REGISTRAR'S SIGNATURE <u>Mr. Herbert Carter</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 28 1959

AUG 18 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Samuel M. Rice, Student Embalmer No. 577

working under my personal supervision.

Student Samuel M. Rice
Signature of Student Embalmer

Signed R. M. Mander

Licensed Embalmer No. 4469

P. O. Address Carrollton

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