

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-002160**  
STATE FILE NUMBER

**FILED VS FEB 29 1960**

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 103

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marceline, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u> c. CITY OR TOWN <u>Ethel, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Ratliff</u>			<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>19</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Feb. 14, 1876</u>	<b>9. AGE (last birthday)</b> <u>84</u>	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>5</u> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Farm</u>		<b>11. BIRTHPLACE (City and state or country)</b> <u>Nebraska City, Nebraska</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>James Barnett Ratliff</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Ellora Jane Henry</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mollie V. Ratliff</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>NO</u> (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Mrs Clella Hawks--Sweet Waters Stat.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Bilateral</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>1955</u> to <u>2-19-60</u> and last saw her/him alive on <u>2-19-60</u> Death occurred at <u>3:00 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>John W. Owens</u> (Degree or title) _____		<b>22b. ADDRESS</b> <u>Marceline, Mo</u>		<b>22c. DATE SIGNED</b> <u>2-20-60</u>			
<b>23a. BURIAL, CREATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>Feb. 21, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ethel Cemetery</u>			
<b>23d. LOCATION (City, town, or county)</b> <u>Ethel, Missouri</u>		<b>24. FUNERAL DIRECTOR</b> <u>Larson Funeral Service, Bucklin, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>2-20-60</u>			
<b>26. REGISTRAR'S SIGNATURE</b> <u>Broovie Owens</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. A. Larson

Licensed Embalmer No. 4037

P. O. Address Bucklin, Missouri

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.