

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017917

FILED VS MAY 12 1968

317

Primary Registration District No. 500

Registrar's No. 1320

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Koch</b>	Length of stay in lb <b>2 years</b>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>208 So. 6th</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Virgil</b> Middle Last <b>Ratliff</b>			4. DATE OF DEATH Month <b>3</b> Day <b>31</b> Year <b>60</b>			
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-5-07</b>	9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>dishwasher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>restaurant</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Nathan Ratliff</b>	13b. MOTHER'S MAIDEN NAME <b>Anna Bounds</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>08-03-7130</b>	17. INFORMANT Address <b>Robert Koch Hospital records</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (e). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalopathy due to anoxia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Pneumonectomy, Right</b>		<b>10 days</b>
	DUE TO (c) <b>Pulmonary Tuberculosis</b>		<b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **3/16/60** to **3/31/60** and last saw **him** alive on **3/31/60**  
Death occurred at **7:10** P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George L. Tucker, M.D.</b>	22b. ADDRESS <b>Robert Koch Hospital, Koch</b>	22c. DATE SIGNED <b>3/31/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Anatomical</b>	<b>1/8/60</b>	<b>Anatomical Board</b>	<b>ST LOUIS, MO.</b>

24. FUNERAL DIRECTOR ADDRESS <b>Rowland-Aker Mortuary Service</b> 4104 Manchester Ave. St. Louis 11, Mo.	25. DATE RECD. BY LOCAL REG. <b>4-22-60</b>	REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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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 Anatomical, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Mary Kearney

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.