

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-023832

FILED VS JUN 24 1960

209

Registration District No. _____ Primary Registration District No. 3043

Registrar's No. 241

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Marion</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Length of stay in lb _____ c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence 1247 A Broadway</u> Inside Limits Yes <input checked="" 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>Marion</u> c. CITY OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1247 A Broadway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>E. RAVENSCRAFT</u> Last <u>SR.</u>			4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>2/15/1900</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>29</u>	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired yard clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wabash Railroad</u>		11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Charels W. Ravenscraft</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Fritz</u>		14. NAME OF HUSBAND OR WIFE <u>Edna Mae Griffen</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>702 05 9596</u>		17. INFORMANT Address <u>Mrs. John Muehring Hannibal Missouri</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>Polycystic liver & ascites</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>		
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.)					
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>on about 6/9/60</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Henry Sweet, Jr. M.D. Coroner</u>			22b. ADDRESS <u>Hannibal Mo</u>		22c. DATE SIGNED <u>6/16/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/16/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
24. FUNERAL DIRECTOR ADDRESS <u>W. Crawford Smith Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>6-16-60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. M. Lucke by Lillian M. Herman</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 ^{Not} embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

H. Crawford Smith

Licensed Embalmer No. 3814

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.