

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038069

Dr. Turner Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 10960 STATE FILE NUMBER

FILED VS NOV 14 1960

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If, institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Length of stay in 1b 32 YRS.	c. CITY OR TOWN SPRINGFIELD Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA, ST. JOHN'S HOSP.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1048 ROANOKE Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BRUCE Middle E. Last RATCLIFF SR.			4. DATE OF DEATH Month OCT. Day 30 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/10/06	9. AGE (last birthday) 54	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) DEARBORN, MO.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME A.B. RATCLIFF		13b. MOTHER'S MAIDEN NAME LAURA BRUCE		14. NAME OF HUSBAND OR WIFE FLORENCE ELSIE RATCLIFF		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 91-42-6830	17. INFORMANT Address DR. BRUCE RATCLIFF JR. SPRINGFIELD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH > 48 Hours
IMMEDIATE CAUSE (a) <u>Infection of myocardium due to arteriosclerosis coronary thrombosis</u>		
DUE TO (b) _____		
DUE TO (c) <u>Hypertensive cardiovascular disease</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) POLYCYTHEMIA VERA.		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 checked="" type="checkbox"/> NO <input 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 <u>12/29/42</u> to <u>10/30/60</u> and last saw ^{her} <u>him</u> live on <u>9/22/60</u> . Death occurred at <u>9:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Glenn T. Turner M.D.		22b. ADDRESS Springfield, Mo.	22c. DATE SIGNED 11/7/60
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/2/60	23c. NAME OF CEMETERY OR CREMATORY GREENLAWN CEMETERY	23d. LOCATION (City, town, or county) (State) SPRINGFIELD, MISSOURI
24. FUNERAL DIRECTOR ADDRESS H.H. LOHMEYER FUNERAL HOME		25. DATE RECD. BY LOCAL REG. 11-9-60	26. REGISTRAR'S SIGNATURE Effie S. Nelson

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

NOV 29 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. H. [Signature]

Licensed Embalmer No. 272

P. O. Address Spring [Signature]

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