# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-007347
STATE FILE NUMBER

AMENDED

Registration District No. 3545 Primary Registration District No. 6205 Registrar's No.

FILED VS FEB 21 1961

1. PLACE OF DEATH
a. COUNTY Texas
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Pierce Twp.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Texas
c. CITY OR TOWN Willow Springs
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Star Route
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First PERRY Middle ANDREW Last RATLIFF
4. DATE OF DEATH Month Feb. Day 12, Year 1961.
5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH 1/13/72
9. AGE (last birthday) 89
IF UNDER 1 YEAR Months 0 Days 29
IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY Stone Mason
11. BIRTHPLACE (City and state or country) Shelby County, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME Maroline McCallister
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Balnche Beltz, Address Willow Spgs., Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorhage — INTERVAL BETWEEN ONSET AND DEATH Unk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Senile degeneration
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 2/12/61 and last saw ~~her~~ him alive on
Death occurred at 9:30 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L A Peterson D.O. (Degree or title) Dr. L. A. Peterson, D.O.
22b. ADDRESS Willow Springs, Mo.
22c. DATE SIGNED 2/13/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/14/61
23c. NAME OF CEMETERY OR CREMATORY Cleek Springs
23d. LOCATION (City, town, or county) (State) Willow Springs (Rural), Mo.

24. FUNERAL DIRECTOR Burns, ADDRESS Willow Springs, Mo.
25. DATE RECD. BY LOCAL REG. 2-16-61
26. REGISTRAR'S SIGNATURE Anna Roberts

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

FEB 23 1961

MAR 2 1961

**STATEMENT BY LICENSED EMBALMER**

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

Student_____
Signature of Student Embalmer

Signed Thomas R. Burns, Thomas R. Burns

Licensed Embalmer No. 4214

P. O. Address Willow Springs,

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.