

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032739

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 156

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0535

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lebanon</u>		c. CITY OR TOWN <u>Lebanon</u>	
Length of stay in 1b <u>13 yrs.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Louise G. Wallace Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Rt. #1</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Roy Ralls</u>			4. DATE OF DEATH Month Day Year <u>Sept. 2, 1963</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>5-14-96</u>
9. AGE (last birthday) <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>grocery</u>	11. BIRTHPLACE (City and state or country) <u>Fredonia, Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James Thomas Ralls</u>	
13b. MOTHER'S MAIDEN NAME <u>Julia Million</u>		14. NAME OF HUSBAND OR WIFE <u>Edna Ralls</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mrs. Edna Ralls, Rt. 1, Lebanon, Mo.</u>		Address	
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>Acute myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>
DUE TO (b) <u>arteriosclerosis, generalized</u>			
DUE TO (c) <u>Diabetes mellitus</u>			<u>5 yrs.</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 <u>8-21-51</u> to <u>9-2-63</u> and last saw him alive on <u>9-2-63</u> Death occurred at <u>9:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>B. B. Hurd, M.D.</u>		22b. ADDRESS <u>Lebanon Mo.</u>	22c. DATE SIGNED <u>9-3-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9-4-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Lebanon, Laclede Co., Mo.</u>
24. FUNERAL DIRECTOR <u>J. J. Shadel</u>		ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-4-19 63</u>
		26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>	

USE BLACK INK OR TYPEWRITER RIBBON

SEP 10 1963

SEP 6 1963

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 Brie M. Abbott

Licensed Embalmer No. 5115

P. O. Address Springfield, Mo.

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.

Permit issued 9-4-1963. M.R.M.