

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.  
*Cartersville*  
**19122**  
File No. \_\_\_\_\_  
Registered No. **421**  
St. \_\_\_\_\_ Ward)

**1. PLACE OF DEATH**

County *Greene* Registration District No. *308*  
Township \_\_\_\_\_ Primary Registration District No. *2201*  
City *Springfield Mo Baptist Hospital*

**2. FULL NAME**

*Janees Ann Ramey*  
(a) Residence No. *1310 S. Jefferson* Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** *Female* **4. COLOR OR RACE** *White* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) \_\_\_\_\_

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Infant*

**6. DATE OF BIRTH** (MONTH, DAY AND YEAR) *June 2, 1930 11:30 AM*  
**7. AGE** YEARS MONTHS *None* If LESS than 1 day, *2* hrs. or *5 1/2* min.

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work *child*  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE** (CITY OR TOWN) *Springfield Missouri*  
(STATE OR COUNTRY)

**10. NAME OF FATHER** *Herbert Ramey*

**11. BIRTHPLACE OF FATHER** (CITY OR TOWN) *Springfield Missouri*  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER** *Delia Sharp*

**13. BIRTHPLACE OF MOTHER** (CITY OR TOWN) *Springfield Missouri*  
(STATE OR COUNTRY)

**14. INFORMANT** *Herbert Ramey*  
(Address) *Springfield Mo.*

**15. FILED** *6-3-30* *For Sharp* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (MONTH, DAY AND YEAR) *June 2 - 1930*

**17. I HEREBY CERTIFY** That I attended deceased from *Birth June 2, 1930* to *June 2, 1930* that I last saw h. *aw* alive on *June 2, 1930* and that death occurred, on the date stated above, at *5 pm* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*1. Prematurity*  
*2. Intra-Cranial Hemorrhage??*  
*3. From birth (duration) yrs. mos. da.*  
CONTRIBUTORY (SECONDARY) *Secondary Asphyxia?*  
(duration) yrs. mos. da.

**18. WHERE** WAS DISEASE CONTRACTED? *161B*  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? *70* DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? *70*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *E. Longhart*, M. D.  
*June 3, 1930* Address *214 7th Jefferson*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** *East Lawn* DATE OF BURIAL *6-3-1930*

**20. URBERTAKER** *Alma Schmeyer* ADDRESS *Springfield*  
*Funeral Home* *Missouri*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION (or nature of service EXERCISED). PHYSICIANS should state any important

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