

AUG 17 1936

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

Do not use this space.

25502

1. PLACE OF DEATH

County BooneRegistration District No. 73Township ColumbiaPrimary Registration District No. 3006City Columbia (No. _____)

File No. _____

Registered No. 209

St. _____ Ward _____

2. FULL NAME

Celia Frances Ravenscraft
(a) Residence, No. 1209 Smith St. 1 Ward 1
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Ravenscraft

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-29-1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 1 0

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓

10. Date deceased last worked at this occupation (month and year) ✓ 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri13. NAME Thos. Tooleau14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Harriett Pegg16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri17. INFORMANT (ADDRESS) Robert Ravenscraft Columbia Mo18. BURIAL, CREMATION OR REMOVAL PLACE New Providence DATE 7-31-3619. UNDERTAKER (ADDRESS) Parter F. Co. WWO Columbia Mo20. FILED 7/31/36 Allie Selby Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-29-193622. I HEREBY CERTIFY, That I attended deceased from July 24, 1936 to 7-29-1936

I last saw him alive on 7-29-1936 Death is said to have occurred on the date stated above, at 12:30 P.

The principal cause of death and related causes of importance were as follows:
apoplexy

Date of onset _____

Other contributory causes of importance: 17

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? NO

If so, specify _____

(Signed) Lloyd Simpson, M. D.(Address) Columbia, Mo

