

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

5374

State File No.

FILED MAR 3 1954

BIRTH NO. _____ REG. DIST. NO. 385 PRIMARY REG. DIST. NO. 3239 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marceline</u>	
c. LENGTH OF STAY (in this place) <u>6yrs.</u>		d. STREET ADDRESS (If rural, give location) -----	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Francis hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u> b. (Middle) <u>Warren</u> c. (Last) <u>Ratliff</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 23, 1954</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <u>2</u> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Oct. 13, 1890</u>	9. AGE (In years last birthday) <u>63</u>	10. MONTHS <u>4</u> DAYS <u>10</u> HOURS <u>0</u> MIN. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Janitor</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nebraska City, Nebr.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>George S. Ratliff</u>	13b. MOTHER'S MAIDEN NAME <u>Arscuela Ratliff</u>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>709-18-3967</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bill Turner 627 Freeman Street Brookfield, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ----- DUE TO (c) <u>Coronary Sclerosis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1-1954, to 2-23-54, that I last saw the deceased alive on 2-22-1954, and that death occurred at 8:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Marceline, Mo.</u>	23c. DATE SIGNED <u>2-23-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 25, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Cambria</u>	24d. LOCATION (City, town, or county) (State) <u>New Cambria, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>2-24-54</u>	REGISTRAR'S SIGNATURE <u>Mary Lou Pughway</u>	401-0	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R. H. Hilliard New Cambria Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

No. 300
10-48

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 _____
Student Embalmer

Signed

H. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria 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 this body is not embalmed, fact should be so stated above.