

39  
5-17-39  
-I X21492

FEB 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1684

State File No.

Registrar's No.

Registration District No. 23

Primary Registration District No. 3005

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County BATES  
(b) City or town Rich Hill Mo  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution

In this community 6.75 years, months or days

3. (a) PRINT FULL NAME DOVEY RAGON

3. (b) If veteran, name war: +  
3. (c) Social Security No. 2

4. Sex F  
5. Color or race W  
6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Louis RAGON  
6. (c) Age of husband or wife if allye 46 years

7. Birth date of deceased MARCH 18 1902 (Month) (Day) (Year)

8. AGE: Years 38 Months 9 Days 15  
If less than one day hr. min.

9. Birthplace MO (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER {  
12. Name FRANK WASSON  
13. Birthplace RICH HILL MO (City, town, or county) (State or foreign country)  
14. Maiden name ROSE DALE  
15. Birthplace KANSAS (City, town, or county) (State or foreign country)

16. (a) Informant Frank Wasson  
(b) Address BONNER SPRINGS KANS.

17. (a) BURIAL (b) Date thereof JAN-5-41 (Month) (Day) (Year)

(c) Place: burial or cremation GREENLAWN CEM

18. (a) Signature of funeral director Booth - Rich Hill

(b) Address Rich Hill Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County BATES

(c) City or town Rich Hill (If outside city or town limit, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 2nd year 12 hour 8 minute M.

21. I hereby certify that I attended the deceased from no to no 19 to no 19; that I last saw her alive on no and that death occurred on the date and hour stated above.

Immediate cause of death Complete Abortion

Due to Absorption of toxin from abortion  
Due to Criminal Abortion

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 141 1/2  
Of autopsy decomposed body in uterus

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury 5

23. Signature Adelle Seaside (M. D. or other) Address Butler Mo Date signed 1-3-41

RECEIVED

District Health Officer No. 7,

District File Number

2-41-248

Date Filed

2-6-41

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

working under my personal supervision.

*myself*

Registered Apprentice No.

Signed

*John G. Underwood*

Licensed Embalmer No.

3585

P. O. Address

*Butler 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 1684

Registration District No. 23

Primary Registration District No. 3005

Registrar's No. 1

1. PLACE OF DEATH

(a) County Bates  
(b) City or town Rich Hill  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Dorcy Razon

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 38 Months 9 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Jan 4, 1941 (Date received local registrar) (b) Clyde J. Allen, M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 2 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature A. G. Wooldridge (M. D. or other)

Address Butler Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

S-1684