

No. 2  
-12-45  
-15-17-39  
X47070

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 11420  
Registrar's No. 3173

FILED APR 8 1948

Registration District No. \_\_\_\_\_ Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3670 Castleman Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Anna Ragan  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Cornelius P. Ragan  
6. (c) Age of husband or wife if alive deceased years \_\_\_\_\_  
7. Birth date of deceased July 8, 1874  
(Month) (Day) (Year)

8. AGE: Years 72 Months 8 Days 15  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jefferson County, Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business At Home

MOTHER FATHER  
12. Name Miles Burke  
13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Bridget Ball  
15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Thos. R. Mothershead  
(b) Address 3670 Castleman Avenue

17. (a) Burial (b) Date thereof March 26, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S. S. Peter & Paul Ch.

18. (a) Signature of funeral director Wm. J. Robert L. & U. Co.

(b) Address 1905 So. Grand Blvd.

19. (a) MAR 25 1947 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3670 Castleman Avenue  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23  
year 1947 hour 7 minute 20 P. M.

21. I hereby certify that I attended the deceased from Feb. 20  
1947 to Mar 23 1947  
that I last saw h. alive on Mar 23 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Cerebral hemorrhage  
Due to arterio-sclerosis  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 61

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 5703 Chippewa Date signed 3/27/47

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**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed.....

*John Ketter*

Licensed Embalmer No. .... *3880* .....

P. O. Address..... *St. Louis, 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.**