

S. No. 2
4-8-43
5-7-39
P 1 X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 9 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15557

State File No. 4282

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bethesda General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community 4 months - 24 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL")
(d) Street No. 1325 O'Hara St.
(If rural, give location) NR
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Kellene Joy Ragan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F / 1. 5. Color or race W 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Nov. 30 1946
(Month) (Day) (Year)

8. AGE: Years NONE Months 4 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business _____

12. Name Clyde Ragan

13. Birthplace Jackson Tenn. 1
(City, town, or county) (State or foreign country)

14. Maiden name Martha Neill

15. Birthplace Blitheville Ark. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Ragan Neill

(b) Address 1325 O'Hara St., Jefferson Barracks

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

(c) Place: burial or cremation NEW-ST. MARCUS CEM.

18. (a); Signature of funeral director W. J. ROBERT & V. Co.

(b) Address 1905 SO GRAND BLVD.

19. (a) APR 26 1947 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1947 hour 5 minute _____ P. M.

21. I hereby certify that I attended the deceased from 2-11-47, 19____, to 4-24-49, 19____;
that I last saw her alive on 4-24-47, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: broncho-pneumonia 2 days

Due to atelectasis and malnutrition

Due to _____
Other conditions (include pregnancy within 3 months of death) 107

Major findings: Of operations none

Of autopsy broncho-pneumonia
atelectasis

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 0

23. Signature W. J. Bredeck (M. D. or other) MD
Address 4660 Maryland Date signed 3/24/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.