

FILED MAY 17 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16519  
State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5465 Registrar's No. 4440

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Springfield</u> OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural/Campbell Twsp.</u> OR TOWN	
c. LENGTH OF STAY (in this place) <u>5 years</u>		d. STREET ADDRESS (If rural, give location) <u>Springfield R.F.D. # 4</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rural N. Campbell Twsp</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>SARAH</u>	b. (Middle) <u>NEAVOLLS</u>	c. (Last) <u>RAGSDALE</u>	4. DATE OF DEATH (Month) (Day) (Year)
				<u>May 6, 1950</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>22 Jan. 1871</u>	9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Marion, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John R. Ragsdale</u>
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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>no</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Dell Lepchenski, Springfield, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Arteriosclerosis</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>7500</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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?
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22. I hereby certify that I attended the deceased from March 1947 to May 6, 1950, that I last saw the deceased alive on Feb. 10, 1950 and that death occurred at 8:00A pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Austaus M.D.</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>5-7-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8 May 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Poplar Bluff</u>	24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>5-9-50</u>	REGISTRAR'S SIGNATURE <u>W.S. Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Paul C. Pheme, Springfield, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0390

MAY 1950

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

*Ralph H. Thirion*

Signed.....

Student Embalmer

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Ma.*

**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.