

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32462**

FILED SEP 26 1950

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **372** PRIMARY REG. DIST. NO. **4543** Registrar's No. **9**

|                                                                                     |  |                                                                                                                                        |  |
|-------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Webster</b>                                       |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo.</b> b. COUNTY <b>Webster</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Seymour</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) <b>Seymour Mo. 1120</b>                                           |  |
| c. LENGTH OF STAY (in this place) _____                                             |  | d. STREET ADDRESS (If rural, give location) <b>0</b>                                                                                   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>0</b>                                    |  |                                                                                                                                        |  |

|                                                                                                              |                           |                                                                       |                                       |                                                                  |                                           |                                                              |                                  |                                |
|--------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------|----------------------------------|--------------------------------|
| 3. NAME OF DECEASED<br>a. (First) <b>Rosenia</b>                                                             |                           | b. (Middle) _____                                                     |                                       | c. (Last) <b>Ragsdale</b>                                        |                                           | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Sept. 8 1950</b> |                                  |                                |
| 5. SEX <b>F</b>                                                                                              | 6. COLOR OR RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b> | 8. DATE OF BIRTH <b>Dec. 26, 1877</b> |                                                                  | 9. AGE (In years last birthday) <b>77</b> |                                                              | IF UNDER 1 YEAR<br>Months   Days | IF UNDER 2 HRS.<br>Hour   Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |                           | 10b. KIND OF BUSINESS OR INDUSTRY _____                               |                                       | 11. BIRTHPLACE (State or foreign country) <b>Webster Co. Mo.</b> |                                           | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                     |                                  |                                |

|                                                                             |  |                                             |  |                                                                       |  |
|-----------------------------------------------------------------------------|--|---------------------------------------------|--|-----------------------------------------------------------------------|--|
| 13a. FATHER'S NAME <b>P. Pendergrass</b>                                    |  | 13b. MOTHER'S MAIDEN NAME <b>Betty Lane</b> |  | 14. NAME OF HUSBAND OR WIFE <b>William Ragsdale</b>                   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> |  | 16. SOCIAL SECURITY NO. _____               |  | 17. INFORMANT'S SIGNATURE OR NAME <b>William Ragsdale Seymour Mo.</b> |  |

|                                                                                                                                                                                                                                 |  |                                                                                                                                                                   |  |                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary edema</b>                                                            |  | INTERVAL BETWEEN ONSET AND DEATH                                         |  |
|                                                                                                                                                                                                                                 |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>arteriosclerotic heart</b> |  |                                                                          |  |
|                                                                                                                                                                                                                                 |  | DUE TO (c) <b>Hypertension</b>                                                                                                                                    |  |                                                                          |  |
|                                                                                                                                                                                                                                 |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                               |  | <b>15:00</b>                                                             |  |
| 19a. DATE OF OPERATION _____                                                                                                                                                                                                    |  | 19b. MAJOR FINDINGS OF OPERATION _____                                                                                                                            |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |

|                                                       |  |                                                                                                        |  |                                                       |  |
|-------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------|--|
| 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 **7-12**, 19**43**, to **9-8**, 19**50**, that I last saw the deceased alive on **9-7**, 19**50**, and that death occurred at **6:54 a.m.**, from the causes and on the date stated above.

|                                                         |  |                          |  |                                                                      |  |
|---------------------------------------------------------|--|--------------------------|--|----------------------------------------------------------------------|--|
| 23a. SIGNATURE <b>G. Berman</b> (Degree or title) _____ |  | 23b. ADDRESS _____       |  | 23c. DATE SIGNED <b>9-13-50</b>                                      |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> |  | 24b. DATE <b>9-10-50</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>              |  |
|                                                         |  |                          |  | 24d. LOCATION (City, town, or county) (State) <b>Webster Co. Mo.</b> |  |

|                                         |  |                                            |  |                                                                |  |                            |  |
|-----------------------------------------|--|--------------------------------------------|--|----------------------------------------------------------------|--|----------------------------|--|
| DATE REC'D BY LOCAL REG. <b>9-17-50</b> |  | REGISTRAR'S SIGNATURE <b>Gilbert Jones</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Kelley, Ferrell-Berman</b> |  | ADDRESS <b>Seymour Mo.</b> |  |
|-----------------------------------------|--|--------------------------------------------|--|----------------------------------------------------------------|--|----------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED SEP 23 1950

Dist. File 950-1470

Date Filed 9-23-50

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. H. Kelley

Licensed Embalmer No. 3334

P. O. Address Fardland 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.