

FILED JUL 7 - 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20327
State File No.
2736
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Nevada	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital		d. STREET ADDRESS (If rural, give location) 603 East Austin	

3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) Colborn c. (Last) RAGAN			4. DATE OF DEATH (Month) (Day) (Year) June 25, 1951		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 7, 1877		9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S.					

13a. FATHER'S NAME John Calvin Ragan		13b. MOTHER'S MAIDEN NAME Diplomah Davidson		14. NAME OF HUSBAND OR WIFE Georgia Ragan	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Georgia Ragan Nevada, Mo.	
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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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac myocardial failure			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Bronchial Asthma			
		DUE TO (c) Uremia			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prostatic Hypertrophy - Benign			24HX

19a. DATE OF OPERATION NO		19b. MAJOR FINDINGS OF OPERATION NO		20. AUTOPSY? YES <input checked="" 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)	
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 June 24, 1951, to June 25, 1951, that I last saw the deceased alive on June 25, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. Lee Hoffman		23b. ADDRESS 1019 Pop Bldg. S. P. MO		23c. DATE SIGNED 6/26/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6/25/51		24c. NAME OF CEMETERY OR CREMATORY --	
				24d. LOCATION (City, town, or county) (State) Nevada, Missouri	

DATE REC'D BY LOCAL REG. 6-27-51		REGISTRAR'S SIGNATURE Sheraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE, Kansas City, Missouri	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. R. N. Hoffmann
City Reg. 3764022

1017

JUL 27 1954

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 *A. J. Callen*

Licensed Embalmer No. *1415*

P. O. Address *K.C. 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.