

# STANDARD CERTIFICATE OF DEATH

State File No. **17451**

**MAY 20 1952**

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

804

BIRTH NO. _____		REG. DIST. NO. <b>274</b>		PRIMARY REG. DIST. NO. <b>3052</b>		Registrar's No. <b>151</b>	
1. PLACE OF DEATH a. COUNTY <b>Pettis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sedalia</b>		c. LENGTH OF STAY (in this place) <b>4 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Ionia</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>				d. STREET ADDRESS (If rural, give location). <b>None</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b> b. (Middle) <b>E.</b> c. (Last) <b>Ragar</b>			4. DATE OF DEATH <b>May 12, 1952</b> (Month) (Day) (Year)				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 2 1879</b>		9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR <b>2</b> Months <b>10</b> Days	IF UNDER 2 HRS. <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Green Ridge, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John Ragar</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Calvert</b>		14. NAME OF HUSBAND OR WIFE <b>Minnie M. Bowlin Ragar</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Virgil Ragar, Sedalia, Mo.</b> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Recurrent Carcinoma of the Left Chest with Metastases.</b> ANTECEDENT CAUSES <b>with Metastases.</b> DUE TO (b) <b>Carcinoma of the Left Arm.</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Senility.</b> Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>15 mos.</b> <b>?</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Medical treatment only. Over please. 1991</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>None.</b>		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) <b>None.</b>		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 <b>over 15 days</b> , to <b>May 12th, 1952</b> , that I last saw the deceased alive on <b>May 12th, 1952</b> , and that death occurred at <b>I.P.H.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Jno. B. Carlisle, M.D.</b> (Degree or title)				23b. ADDRESS <b>Sedalia, Missouri.</b>		23c. DATE SIGNED <b>5-13-52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>May 14, 52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ionia Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Ionia, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>5/14/52</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>Sedalia, Mo.</b>			

Some years ago this man had a tumor removed from the left upper arm that afterward proved to be malignant. He was treated at the Mayo Clinic and the left arm, clavicle and scapula were removed. He was then treated by X.Rays. His death was due to recurrence. I dont have the date of the original operation.

Jno. B. Carlisle, M.D.

*Jno. B. Carlisle M.D.*  
May 13th, 1952.

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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.

Student .....  
Student Embalmer

Signed *P. E. Baker* .....

Licensed Embalmer No. *2419* .....

P. O. Address *Sedalia* .....

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.