

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29927**  
Registrar's No. **7845**

FILED SEP 3- 1952

BIRTH NO. **41227** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town)		a. STATE	b. COUNTY
c. LENGTH OF STAY (In this place township)		Missouri <b>2179</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township): OR TOWN	
St. Johns Hospital		St. Louis	
d. STREET ADDRESS (If rural, give location)		17	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First)	b. (Middle)	c. (Last)	
ALICE	JEANE	RAGSDALE	
5. SEX		6. COLOR OR RACE	
Female /		White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Single		June 21, 1952	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	
0		11. BIRTHPLACE (City and State or Foreign Country)	
1		20	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
U.S.A.		James Ragsdale	
13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Ecel Jones		-	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		No	
17. INFORMANT'S SIGNATURE OR NAME		ADDRESS	
James Ragsdale		3043a, St. Vincent	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I infant		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Unbearable Cause unk. 1 mo.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b)		Adrenal insufficiency	
		DUE TO (c)		Dehydration	
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input checked="" 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)	
				7730	
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 Aug 17, 1952, to Aug 18, 1952, that I last saw the deceased alive on Aug 18, 1952, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Saul J. Fitch MD 23b. ADDRESS 3284 IVANHOE 23c. DATE SIGNED Aug 18, 1952

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 8-18-52 24c. NAME OF CEMETERY OR CREMATORY Owens Cemetery 24d. LOCATION (City, town, or county) (State) Dover, Arkansas

DATE REC'D BY LOCAL REG. AUG 18 1952 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin Funeral Home, St. Louis, Mo.

296 (Licensed Embalmer's Statement on Reverse Side)

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

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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

*James R. Chapman*

Licensed Embalmer No. 45-57

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.