

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

40622

State File No. _____
Registrar's No. **10745**

FILED DEC 12 1952

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		Registrar's No. 10745			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2123					
d. FULL NAME OF HOSPITAL OR INSTITUTION 5455 Delmar Blvd				d. STREET ADDRESS (If rural, give location) 12 5455 Delmar Blvd.							
3. NAME OF DECEASED (Type or Print) a. (First) Katherine			b. (Middle) Belle			c. (Last) Ragsdale			4. DATE OF DEATH (Month) (Day) (Year) 11-20-52		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Oct 7 1877		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Memphis Tenn			12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Unknown Davidson			13b. MOTHER'S MAIDEN NAME Unknown Wade			14. NAME OF HUSBAND OR WIFE Edward Ragsdale					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Mrs. Callie Downey		ADDRESS 5457 Delmar Blvd.					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH ca. 2 years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic heart failure				DUPLICATE OF (b) Generalized arteriosclerosis							
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUPLICATE OF (c) _____				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 type="checkbox"/> NO <input checked="" 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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4:50 p.m.							
22. I hereby certify that I attended the deceased from 10/24 1948 , to 4/20 1952 , that I last saw the deceased alive on 11/18 1952 , and that death occurred at 9:50 p.m. , from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) Ruth Winstanley M.D.				23b. ADDRESS 462 N. Taylor				23c. DATE SIGNED 11/21/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-24-52		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo., Missouri					
DATE REC'D BY LOCAL REG. NOV 2 1952		REGISTRAR'S SIGNATURE J. Earl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe			ADDRESS 4700 Washington Blvd.			

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

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 W. W. Wilkinson

Licensed Embalmer No. 3570

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.