No. 300
10.48

FILED AUG 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26588

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 93

1. PLACE OF DEATH
a. COUNTY: CLAY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): EXCELSIOR SPRINGS
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: EXCELSIOR SPRINGS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI b. COUNTY: LAFAYETTE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LEXINGTON
d. STREET ADDRESS (If rural, give location): 816 SOUTH ST.

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3. NAME OF DECEASED (Type or Print)
a. (First): MARY b. (Middle): A c. (Last): KEY

4. DATE OF DEATH (Month) (Day) (Year): AUG. 22, 1954

5. SEX: FEMALE **6. COLOR OR RACE:** WHITE **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): MARRIED **8. DATE OF BIRTH:** JULY 14, 1891 **9. AGE** (In years last birthday): 63 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEKEEPING
11. BIRTHPLACE (State or foreign country): DOVER, MO.
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: CLAY RAGSDALE
13b. MOTHER'S MAIDEN NAME: RUTH O'DONNEL
14. NAME OF HUSBAND OR WIFE: JOHN C. KEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S SIGNATURE OR NAME: HOSPITAL RECORDS ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arterio-Sclerosis — ?

DUE TO (c) Chronic Myocarditis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1954, *to* 8-22, 1954, *that I last saw the deceased alive on* 8-22, 1954, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Gay (Degree or title) M.D.
23b. ADDRESS: Lexington Mo.
23c. DATE SIGNED: 8-24-54

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 8-22-54
24c. NAME OF CEMETERY OR CREMATORY: MACHPELAH
24d. LOCATION (City, town, or county) (State): LEXINGTON, MO.

DATE REC'D BY LOCAL REG.: 8/24/54
REGISTRAR'S SIGNATURE: Caroline Hutchings
25. FUNERAL DIRECTOR'S SIGNATURE: Claude Pickard
ADDRESS: Ex Springs Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 17 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 Lindell Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.