

REGISTRATION DISTRICT NO. 318 Primary Registration District 1003 Registrar's No. 11380-60-044092

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS DEC 2 1960

11380-60-044092
 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Length of stay in 1b		c. CITY OR TOWN Mo St. Francois	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis- Little Rock Hospitals, Inc.				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) P.O. Box 121	
3. NAME OF DECEASED (Type or print) First Middle Last John Lavert Ragsdale				4. DATE OF DEATH Month Day Year November 26 1960			
5. SEX Male		6. COLOR OR RACE White		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-15-1888	
9. AGE (last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penr. Rd House Laborer		11. BIRTHPLACE (City and state or country) Unknown		12. CITIZEN OF WHAT COUNTRY Unknown	
13a. FATHER'S NAME John Ragsdale				13b. MOTHER'S MAIDEN NAME Myra Harrol		14. NAME OF HUSBAND OR WIFE Lillie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 702-14- 7121		17. INFORMANT Address Lillie Ragsdale Bismarck, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO (b) _____ DUE TO (c) 151x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year				20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from Sept. 28, 1960 to Nov. 26, 1960 and last saw him alive on Nov. 25, 1960 Death occurred at 5.20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE E.R. Sheridan, M.D. (Degree or title)				22b. ADDRESS 1755 SO. Grand Blv'd		22c. DATE SIGNED 11-26-60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11-28-60		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Bismarck, Missouri	
24. FUNERAL DIRECTOR John Shipman ADDRESS Bismarck, Mo.				25. RECORDED BY LOCAL REG. NOV 26 1960		26. REGISTRAR'S SIGNATURE Loed Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John N. Shipman

Licensed Embalmer No. 4881

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.