

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0045131

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 212 Registrar's No. 3042A

FILED DEC 7 1966

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | c. CITY OR TOWN MARSHFIELD | |
| Length of stay in lb 3 DAYS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in Hospital, give location) HOSPITAL OR INSTITUTION BURGE HOSP | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|--|---|---|---|
| 3. NAME OF DECEASED (Type or print) REBECCA A RAGSDALE | | | 4. DATE OF DEATH Month NOV Day 25 Year 1966 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-15-1886 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months Days 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 | | 11. BIRTHPLACE (City and state or country) MISSOURI | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A | | 13a. FATHER'S NAME WILLIAM GEORGE | | 13b. MOTHER'S MAIDEN NAME MAHALA OWENS | |
| 14. NAME OF HUSBAND OR WIFE PLEAMON GEORGE SEYMOUR MO | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT PLEAMON GEORGE SEYMOUR 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) ASHD c congestive failure | | INTERVAL BETWEEN ONSET AND DEATH | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Pneumonia | | 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 | |
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|---|---|--|--|
| 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.) | |
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|---------------------------------------|------------------|--|--|------------------------------|--------|-------|
| 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 **Nov 22, 1966** to **Nov 25, 1966** and last saw her alive on **Nov 25, 1966**
Death occurred at **745 P** on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|-------------------|--|------------------------------------|
| 22. SIGNATURE D Dean Cunningham, M.D | (Degree or title) | 22b. ADDRESS Springfield, Mo | 22c. DATE SIGNED 12-3-66 |
|--|-------------------|--|------------------------------------|

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|--|--------------------------------|--|---|---------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 11-28-1966 | 23c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL | 23d. LOCATION (City, town, or county) WEBSTER Co MO | (State) |
|--|--------------------------------|--|---|---------|

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| 24. FUNERAL DIRECTOR BARBER-EDWARDS-MARSHFIELD | 25. DATE RECD. BY LOCAL REG. 12-6-66 | 26. REGISTRAR'S SIGNATURE Bernice W. Kelly |
|--|--|--|

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0397

2 1120

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4 1

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9 4200

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12 1-0

13

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 _____
Signature of Student Embalmer

Signed _____

R. W. Barker

Licensed Embalmer No. 3848

P. O. Address Wm Grove 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.