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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No. 399

Primary Registration District No. 166

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 1
(d) Length of stay: In hospital or institution 4 days
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City, Mo.
(d) Street No. 1505 E. 35th St.
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Horace W. Ragan 250

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Minnie P. Ragan 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased October 25, 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 1 Days 2 If less than one day
hr. _____ min. _____

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business _____

12. Name Stephen C. Ragan

13. Birthplace Kentucky
(State or foreign country)

14. Maiden name Josephine Giles

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Minnie P. Ragan

(b) Address 1505 East 35th Street

17. (a) Burial (b) Date thereof Nov 29, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Moriah

18. (a) Signature of funeral director Freeman Mortuary

(b) Address _____

19. (a) Nov 29 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 27th
year 1939 hour 2 minute 20 P. M.

21. I hereby certify that I attended the deceased from March 30th
1939, to Nov. 27th, 1939;
that I last saw him alive on 11-27-,
and that death occurred on the date and hour stated above.

Immediate cause of death
Bilateral confluent bronchopneumonia
Fatty degeneration of heart
Due to Carcinoma of tongue (resected)
Salivary fistula (repaired)

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy See above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature P. J. De Maria M.D. or other _____

Address Supt. K.C. Gen. Hospital Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Rev. 5-17-39 I 191511

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

3-30-34

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Elmer E. Korman

Licensed Embalmer No. 481

P. O. Address Kansas City, 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, above space should be left blank.