

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.

Registration District No. 827 Primary Registration District No. 4500

**1. PLACE OF DEATH:**  
 (a) County Shelby  
 (b) City or town Clarence  
 (c) Name of hospital or institution: 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community \_\_\_\_\_  
 years, months or days

3. (a) PRINT FULL NAME Enoch V. Ragland  
 3. (b) If veteran, name war ✓  
 3. (c) Social Security No. ✓

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Viola Ragland 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased March 26 1869  
 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Marion Co. Mo.  
 (City, town or county) (State or foreign country)

10. Usual occupation Printer

**MOTHER FATHER**  
 12. Name Frank T. Ragland  
 13. Birthplace Mo.  
 14. Maiden name Sarah E. Griffith  
 15. Birthplace Mo.

16. (a) Informant's own signature Mr. Albert Long  
 (b) Address Clarence, Mo.

17. (a) Burial (b) Date thereof 3-17-1940  
 (Burial, cremation, or other) (Month) (Day) (Year)

18. (a) Signature of funeral director Stephens & Gooding  
 (b) Address Marion, Mo.

19. (a) 4-1-1940 (b) ROY HAMILTON  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Mo. (b) County Shelby  
 (c) City or town Clarence  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month March day 16  
 year 1940 hour 2 minute 30 a.m.

21. I hereby certify that I attended the deceased from March 1927, 19\_\_\_\_ to March 1940, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Urethral stricture with urinary retention 20 yrs  
 Due to urethritis 20 yrs  
 Due to nonspecific infection  
 Other conditions Depressive psychosis 2 mo  
 (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings: posterior urethral stricture  
 Of operations \_\_\_\_\_  
 Of autopsy none  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_ no  
 (b) Date of occurrence \_\_\_\_\_ no  
 (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? no  
 (Specify type of place)  
 (e) Means of injury \_\_\_\_\_ no  
 While at work? no  
 23. Signature D. L. Naylor M.D. (M. D. or other)  
 Address Clarence, Mo Mar. 18 1940 Date signed

RECEIVED  
District Health Officer No. 10  
District File Number H-40-824  
Date Filed APR 11 1940

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 C. L. Stephens  
Licensed Embalmer No. 3057  
P. O. Address Macon, 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.