

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 0
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: ⁹⁴⁹

(a) State Illinois (b) County Alexander

(c) City or town Cairo
(If outside city or town limits, write "RURAL")

(d) Street No. 11 NR
(If rural, give location)

(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Emma Katherine Ragsdal

3. (b) If veteran, name war. None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife. None

6. (c) Age of husband or wife if alive. None years

7. Birth date of deceased March 6, 1903
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>10</u>	<u>16</u>	hr. min.

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

10. Usual occupation Operator

11. Industry or business 56

12. Name Joseph Ragsdal

13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Mary Hayes

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

MOTHER FATHER

16. (a) Informant Mrs. Joseph Conroy

(b) Address Cairo, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/23/43
(Month) (Day) (Year)

(c) Place: burial or cremation Cairo, Illinois

18. (a) Signature of funeral director Albert H. Hoppe, Inc

(b) Address 4700 Washington Blvd.

19. (a) JAN 24 1943 (Date received local registrar) J. F. Budack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22
year 1943 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from 1-10-43 to 1-22-43
that I last saw 2 alive on 1-22-43, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia - Result of paralysis - Arous under spinal muscles - Leg -

Due to Spinal Cord Tumor
Upper Cervical Cord

Due to Paralysis - Arous under spinal muscles - Leg -

Other conditions Non-malignant tumor
(Include pregnancy within 3 months of death)

Major findings: Spinal Cord Tumor
Paralyzed. 1 yr ago

Of operations None

Of autopsy None

Duration

PHYSICIAN

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) _____

(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 A. Anderson (M. D. or other) _____
Address 4922 Mon. Law Date signed 1-23-43

5/14/41
5/14/41

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 *Wilford G Burnley*
Licensed Embalmer No. *4202*

P. O. Address.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 775

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Baptist Hospt.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULLNAME Emma Katherine (Ragsdale)

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-25-43 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Alexander
 (c) City or town Cairo
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22nd
 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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) _____
 (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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

664