

S. No. 2-
M-2-43
5-17-39
1 X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37475

State File No.

FILED DEC 3 1949

Registration District No. 3 149

Primary Registration District No. 1002

Registrar's No. 4896

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

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3626 AGNES AVENUE
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 1 YEAR (Specify whether years, months or days)

3. (a) PRINT FULL NAME MRS ORPHA JOSEPHINE RAGER

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife MR. J. WESLEY RAGER JR.

6. (c) Age of husband or wife if alive UNR years

7. Birth date of deceased JULY 22 1904
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
39	3	28	hr. min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name D. H. SAWYER

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

14. Maiden name ORTA

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

16. (a) Informant MR. J. WESLEY RAGER JR.

(b) Address 3626 AGNES AVENUE

17. (a) BURIAL (b) Date thereof NOV. 19 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CHILLICOTHE MISSOURI

18. (a) Signature of funeral director D. H. Sawyer

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 11-17-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

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

(d) Street No. 3626 AGNES AVENUE
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 19TH
year 1943 hour 12 minute 30 P.M.

21. I hereby certify that I attended the deceased from Oct 1
1943, to Nov 19 1943

that I last saw h. alive on Nov 2 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Heart Block (Coronary arteriosclerosis)

Duration 10/43

Due to ASA

Due to ASA

Other conditions: Chronic Myocardial Degeneration
(Include pregnancy within 6 months of death)

PHYSICIAN

Major findings:
Of operations
Of autopsy

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 D. E. Brown (M. D. or other) _____
Address 1612 Crawford City signed 11/19/43

612 Professional Society
12-6

MAR 1 1956

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 Emile M. Culhoun

Licensed Embalmer No. 3506

P. O. Address Kemo

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.