

FILED MAR 21 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 6076

Registrar's No. 593

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3106 Rex
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 40 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 3106 Rex
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Mary Ragsdale

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Hansford Ragsdale 6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased Dec 30 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
81 2 13 hr. min.

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

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Enoch Robertson

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

14. Maiden name Do not know

15. Birthplace Do not know
(City, town, or county) (State or foreign country)

16. (a) Informant Lester Ragsdale

(b) Address Salem Mo

17. (a) Removal (b) Date thereof 3/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marguand Mo

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 9222 Lackland Overland Mo

19. (a) 3-17-47 (b) Keith Allen M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13
year 1947 hour _____ minute 7:15 P. M.

21. I hereby certify that I attended the deceased from Mar 1-47
to Mar - 12 1947
that I last saw her alive on Mar - 12 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Influenza - (9)

Due to 1

Other conditions Per a febrilis

Major findings: Of operations _____

Of autopsy _____

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?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Keith Allen M.D. (M. D. or other) _____
Address Boulard 14 Mo Date signed 3-13-47

Duration

5 days

7 Days

years

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Al C. Ortman*
Licensed Embalmer No. *3478*
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.