

FILED DEC 3 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37836

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 4275 Registrar's No. 91

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>LAWRENCE</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>LAWRENCE</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MAVONVILLE</u>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>MAVONVILLE</u>  |  |
| c. LENGTH OF STAY (in this place) <u>11</u>  |  | d. STREET ADDRESS (If rural, give location) <u>City</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>CITY OF MAVONVILLE</u> |  |   |  |

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>ERASTUS</u> b. (Middle) <u>Ragsdale</u> c. (Last) <u>Ragsdale</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>NOV 6-1949</u> |   |   |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>                 |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u> |   |
| 8. DATE OF BIRTH <u>July 12, 1866</u>  |  | 9. AGE (In years last birthday) <u>83</u> |  | IF UNDER 1 YEAR Days <u>3</u> Hours <u>25</u> Min.                          |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>              |  |   | 10b. KIND OF BUSINESS OR INDUSTRY                          |   | 11. BIRTHPLACE (State or foreign country) <u>GREEN COUNTY</u> |
|  |  |   |  |   | 12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>                       |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 13a. FATHER'S NAME <u>ASA Ragsdale</u>  |  | 13b. MOTHER'S MAIDEN NAME <u>Josephine Hilton</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Single</u>                                    |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u> |  | 16. SOCIAL SECURITY NO. <u>NONE</u>               |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. BERTHA TAYLOR AURORAMO</u> |  |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u> |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  | <u>1701</u>                                       |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19a. DATE OF OPERATION                   |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)                       |  |

|  |  |  |  |                            |  |
|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? |  |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from 11/6, 1949, to 11/6, 1949, that I last saw the deceased alive on 11/6, 1949, and that death occurred at 11:30 A.m., from the cause and on the date stated above.

|   |  |   |  |                                 |  |
|---|--|---|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>Dr Wayne W. Weaver M.D.</u> |  | 23b. ADDRESS <u>1st St. Louis Mo 5427A Southwest Ave.</u> |  | 23c. DATE SIGNED <u>11/6/49</u> |  |
|---|--|---|--|---------------------------------|--|

|   |  |                          |  |  |  |  |  |
|---|--|--------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> |  | 24b. DATE <u>11/9/49</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u> |  | 24d. LOCATION (City, town, or county) (State) <u>Aurora MO</u> |  |
|---|--|--------------------------|--|--|--|--|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. <u>Nov 17-49</u> |  | REGISTRAR'S SIGNATURE <u>Oral Mc Nott</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>157 1/2 Cedar St. Marsh Aurora Mo</u> |  |
|---|--|---|--|---|--|

RECEIVED NOV 23 1949  
District Health Office No. 6,  
District File Number 1149-1281  
Date Filed 11-30-49

**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 \_\_\_\_\_

*Myself*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Paul L. Smith*

Licensed Embalmer No. 3812

P. O. Address Quora 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, fact should be so stated above.