

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 25 1957

STATE FILE NUMBER  
**38014**  
Registrar's No. **9668**

Registration District No. **318** Primary Registration District No. **1003**

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>01 1650 So. 39th St.</b>		Length of stay in lb <b>2 1/2 yrs.</b>	d. STREET ADDRESS <b>1650 So. 39th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Clark L. Ragan</b>			4. DATE OF DEATH <b>October 15, 1957</b>		Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1902</b>		9. AGE (In years at birthday) <b>54</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance Work</b>		11. BIRTHPLACE (City and state or country) <b>Dent Co., Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>James Ragan</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Perry</b>	
14. NAME OF HUSBAND OR WIFE <b>Bonnie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Bonnie Ragan,</b>		Address <b>1650 So. 39th St.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331A</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>2 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY. Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>14 Jan 1954</b> to <b>15 Oct 57</b> and last saw him alive on <b>1 Oct 1957</b> Death occurred at <b>15 Oct 57</b> <b>1429</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>S. D. Wosher</b>		(Degree or title) <b>MD</b>		22b. ADDRESS <b>1657 So Grand</b>	
22c. DATE SIGNED <b>10/16/57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-17-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		23d. LOCATION (City, town, or county) <b>Rolla, Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe,</b>		ADDRESS <b>4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 16 57</b>	
26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>		m JB			

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

