

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012091

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 636

AMENDED ✓

FILED VS. MAR 16 1961

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond Hts.</u> | | Length of stay in 1b <u>3 Weeks</u> | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>3261 Suson Ct.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ELSIE RAGAN</u> | | | 4. DATE OF DEATH Month Day Year <u>Mar. 5 1961</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-27-1907</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist-City of St. Louis</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Mo.</u> | 9. AGE (last birthday) <u>53</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>George Dill</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rose Potter</u> | 14. NAME OF HUSBAND OR WIFE <u>Late Randolph Ragan</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No None</u> | | 17. INFORMANT Address <u>Barbara Beckman 3261 Suson Ct.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Calcific Aortic Stenosis</u> DUE TO (c) <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>411X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> <u>3 yrs.</u> <u>?</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m. Month, Day, Year | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>11/6/60</u> to <u>3/5/61</u> and last saw her/him alive on <u>3/4/61</u> . Death occurred at <u>6:45 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Carroll R. Grubel MD</u> | | 22b. ADDRESS <u>16 Hampton Village</u> | 22c. DATE SIGNED <u>3/6/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>Mar. 8, 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Picker Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Kriegshauser 4228 S. Kingshighway Blvd.</u> | | 25. DATE RECD. BY LOCAL REG. <u>3-7-61</u> | 26. REGISTRAR'S SIGNATURE <u>John M. Murphy M.D.</u> |

DATE AMENDED

INSTEAD OF DOCUMENT

BY AFFIDAVIT OF SHOULD READ

MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William S. White

Licensed Embalmer No. 4291

P. O. Address 4228 W. Long

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.