RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59-025372

FILED VS AUG 10 1959 149 Registration District No. ____ Primary Registration District No. 1002 Registrar's No. 3608 STATE FILE NUMBER

DED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | Length of stay in 1b: 2 wks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital | Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cass
c. CITY OR TOWN Harrisonville | Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) RR #3 | Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First John Middle Franklin Last Ragsdale

4. DATE OF DEATH: Month July Day 26 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 2-8-1885
9. AGE (last birthday): 74
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HR: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm.
11. BIRTHPLACE (City and state or country): S. Green Field, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Franklin Ragsdale
13b. MOTHER'S MAIDEN NAME: Mary E. Buckner
14. NAME OF HUSBAND OR WIFE: Zula Ragsdale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 490-42-2524
17. INFORMANT Address: Lynn Ragsdale, Harrisonville, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Circulatory Failure.	4 days.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Carcinoma of Colon (Splenic	6 mo.
DUE TO (c)	flexure) post-operative.	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 7-12-'59, to 7-26-'59 and last saw her/him alive on 7-26-'59
Death occurred at 1:45 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): E. A. Wilkinson, M.D.
22b. ADDRESS: 1332 Professional Bldg
22c. DATE SIGNED: 7-26-'59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 7-26-59
23c. NAME OF CEMETERY OR CREMATORY: Lockwood Cemetery
23d. LOCATION (City, town, or county) (State): Lockwood Missouri

24. FUNERAL DIRECTOR ADDRESS: Atkinson Dickey Harrisonville, Mo.
25. DATE RECD. BY LOCAL REG.: 7-26-59
26. REGISTRAR'S SIGNATURE: Neva Mitchell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF Atkinson DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Robert Atkinson

Signature of Student Embalmer

Licensed Embalmer No. 4902

P. O. Address Harrisonville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.