

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Missouri
Township Madison
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 552- File No. 33531
Primary Registration District No. 5745 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Maley Mack Ritter

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH could not find any date of birth or last played (Day) _____ (Year) _____
AGE a friend thought him about 5-1 yrs. (If LESS than 1 day, ___ hrs. or ___ min.?)
OCCUPATION (a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Don't know

PARENTS
NAME OF FATHER John Ritter
BIRTHPLACE OF FATHER (City or town, State or foreign country) Madison Co Ind
MAIDEN NAME OF MOTHER Susan Ellsworth
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Madison Co Ind

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Levi Stewart
(ADDRESS) Madison Ind

Filed Oct 20, 1913 - J B Cunningham REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 19, 1913
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 9, 1913, to Oct 19, 1913, that I last saw him alive on Oct 19, 1913, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Complication of meningitis and pneumonia

108
89A (Duration) _____ yrs. _____ mos. _____ ds.

Contributory 79A (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James B Cunningham, M. D. (Address) Madison Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Friend Cemetery DATE OF BURIAL Oct 20, 1913

UNDERTAKER Friends ADDRESS Madison Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;*

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Mercer
Township Madison
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Registration District No. 555 File No. _____
Primary Registration District No. 5748 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Maly Mack Ritter

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>M</u>	DATE OF DEATH <u>Oct 19</u> , 191 <u>3</u> (Month) (Day) (Year)	
DATE OF BIRTH _____, _____, 191 <u>3</u> (Month) (Day) (Year)			I HEREBY CERTIFY, that I attended deceased from <u>Oct 19</u> , 191 <u>3</u> , to <u>Oct 19</u> , 191 <u>3</u> , that I last saw him alive on <u>Oct 19</u> , 191 <u>3</u> , and that death occurred, on the date stated above, at _____ m.	
AGE _____ mos. _____ ds.			IF LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____			The CAUSE OF DEATH* was as follows: <u>Complication of Meningitis and Pneumonia (Lobar)</u> <u>Otitis with Perforation of Tympanic Membrane Extending to Middle Ear</u> <u>Contributory</u> (Duration) _____ yrs. _____ mos. _____ ds.	
BIRTHPLACE (City or town, State or foreign country) _____			(Signed) <u>J. B. Cunningham</u> M. D. <u>Oct 19</u> , 191 <u>3</u> (Address) <u>Madison Mo</u>	
PARENTS	NAME OF FATHER _____		(Duration) _____ yrs. _____ mos. _____ ds.	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) _____		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	MAIDEN NAME OF MOTHER _____		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____		At place of death: _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____			Where was disease contracted If not at place of death? _____	
(ADDRESS) _____			Former or usual residence _____	
Filed <u>Oct 20</u> , 191 <u>3</u> <u>J. B. Cunningham</u> REGISTRAR			PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____, 191 <u>3</u>	
			UNDERTAKER _____ ADDRESS _____	

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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