

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

Do not use this space.

36941

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Jaw Primary Registration District No. _____
 City Kansas City (No. 2947) Baltimore St. _____ Ward _____

File No. _____
 Registered No. 4764

2. FULL NAME

Sophia Susana Ritter
 (a) Residence No. 2947 Baltimore St. Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 40 yrs. mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Ritter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 29, 1841

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	86	7	17	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) On Ocean

10. NAME OF FATHER Bew Schindhelm

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Barbara Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs John Rick
 (Address) 2947 Baltimore

15. FILED 12-17, 1927 M M Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 16 1927
 17. I HEREBY CERTIFY, That I attended deceased from Dec 14/27 to Dec 16, 1927
 that I last saw him alive on Dec 16, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
Coronary Sclerosis
General Arteriosclerosis
Paralysis (duration) 10 yrs. mos. _____ ds.

CONTRIBUTORY (SECONDARY) Paricula Dibrillation - Broncho
pneumonia (duration) _____ yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED 1927
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy Examination
 (Signed) Carl H. Busch, M. D.

1927 (Address) St. Louis - Trinity Lutheran Hosp.
 *State the DISEASE CAUSING DEATH, or in detail the MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, HOMICIDAL, or SUICIDAL. Yes No

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Washington DATE OF BURIAL Dec 19 1927

20. UNDERTAKER N.H. Newcomer's Sons ADDRESS St. Louis

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.

30th & 1st