LOCAL REGISTRAR'S REPORT DO NOT TEAR LEAF OUT

MAR 21 1928

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

1. PLACE OF DEATH.
County: Newton — Registration District No.: 611 — File No.: 5759
Township: Buffalo — Primary Registration District No.: 5813 — Registered No.:
City: ~~Seneca R.D.1~~ — St.: — Ward:

2. FULL NAME: Lucile Ritter

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): ✓

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 26-28

7. AGE — YEARS: 1 — MONTHS: 11 — DAYS: 28 — If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ✓
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Seneca
(STATE OR COUNTRY): RD1 Mo

PARENTS
10. NAME OF FATHER: Floyd Ritter
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Seneca
(STATE OR COUNTRY): RD1 Mo
12. MAIDEN NAME OF MOTHER: Gertrude Hasholzer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Seneca
(STATE OR COUNTRY): Mo

14. INFORMANT: Floyd Ritter
(Address): Seneca Mo

15. FILED: 3/24 1928 — C. E. Morris, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/21 1928

17.
I HEREBY CERTIFY, That I attended deceased from 2-20, 1928, to 2-21, 1928, that I last saw ~~he~~ alive on 2-21, 1928, and that death occurred, on the date stated above, at 10 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Burns Water Poison
Scalding Water off Stove on Her Child
18 hr (duration) ... yrs. ... mos. ... ds

CONTRIBUTORY (SECONDARY) ... (duration) ... yrs. ... mos. ... ds

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No — DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. C. Barnard, M. D.
, 19 (Address) Seneca Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Seneca — DATE OF BURIAL: 2/22 1928

20. UNDERTAKER: Norman E. Mitchell — ADDRESS: Seneca Mo

IN 25. 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

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH "A"

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St.

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF D

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended d
....., 19....., to .....
that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from (1) MEANS AND NATURE OF INJURY, and (2) whether AC HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

20. UNDERTAKER