

31 1928

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

Do not use this space.

1. PLACE OF DEATH

County Gasconade
Township
City

Registration District No. 307
Primary Registration District No. 6731

File No. 12855
Registered No. _____
St. _____ Ward

2. FULL NAME

Samuel B. Ridenhaure

(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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68

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

9. BIRTHPLACE (CITY OR TOWN) not known
(STATE OR COUNTRY)

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Luther Walls
(Address) Owensville Mo

15. FILED 4-17-28 19 28 Ed Brung md
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 16 19 28

17. I HEREBY CERTIFY That I attended deceased from April 15th 1928 to April 16 1928 (that I last saw him alive on April 15 1928, and that death occurred, on the date stated above, at 10:45 p.m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS
Uremic Poisoning
120 (duration) yrs. mos. 6 ds.

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

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

0 DID AN OPERATION PRECEDE DEATH. no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Chas A Wood M.D.

, 19 (Address) Owensville 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Owensville Cemetery DATE OF BURIAL April 18 1928

20. UNDERTAKER W.F. Gettenbacher ADDRESS Owensville Mo

RECORD
No. 21—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.

CAUSE OF DEATH in plain

Exact station

1
to

X

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Gasconade Registration District No. 302 File No. 6
 Township Clay Primary Registration District No. 6231 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Samuel B. Ridenhouse
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED s (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) _____

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 4-20-28 a. Bunge REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 16 19 28

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above.)

THE CAUSE OF DEATH WAS AS FOLLOWS:

Wetate Poisoning
Chronic
Interstitial Nephritis
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) not known
 (duration) _____ yrs. _____ mos. _____ ds.

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) _____, M. D.
 _____, 19____ (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

EXACTLY. PHYSICIAN'S should state at least one OCCUPATION is very important. REGISTRATION should be carefully supplied. AGE should be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-12855