

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

Do not use this space.

5883

1. PLACE OF DEATH

County Jackson
Township Blue
City Independence (No. Indep. Sanitarium)

Registration District No. 398
Primary Registration District No. 3019

File No. _____
Registered No. 63
St. _____ Ward _____

2. FULL NAME

(a) Residence No. County Road Indep. Sanitarium 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mollie Ritter</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 6, 1856</u>		
7. AGE	YEARS <u>76</u>	MONTHS <u>10</u>
	DAY <u>16</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-22 1933

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1932 to 7-22, 1933 that I last saw h. alive on 2-21, 1933 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
ascumous prostate
510
5/10 (duration) 1 yrs. 6 mos. 0 ds.

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

9. BIRTHPLACE (CITY OR TOWN) Jackson Co., Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER John Ritter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT John Ritter
(Address) 427 North Union

15. FILED Feb 23 1934 Dr. F. L. Cook REGISTRAR

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS? clinical mic
(Signed) J. W. Greene, M. D.
7-23, 1933 (Address) Independence 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 Woods Chapel Indep. DATE OF BURIAL Feb 24 1933

20. UNDERTAKER Dr. F. L. Cook ADDRESS _____

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.

RECORD THIS IS A PERMANENT RECORD

