

Registration District No. **379**

Primary Registration District No. **1002**

Registrar's No. **4219**

1. PLACE OF DEATH:  
(a) County **Jackson**  
(b) City or town **Hansons city**  
(c) Name of hospital or institution: **ITC Gen Hospt**  
(d) Length of stay: In hospital or institution **9 days**  
In this community **All life**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **Jackson**  
(c) City or town **Hansons City**  
(d) Street No. **3317 E 30-ter**  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **La Vesta Ribaste**  
(b) If veteran, name war **No**  
(c) Social Security No. **No**

20. DATE OF DEATH: Month **May** day **2**  
year **1939** hour **6** minute **40-9** M.

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**  
6. (b) Name of husband or wife **Chas Ribaste** 6. (c) Age of husband or wife if alive **43** years  
7. Birth date of deceased **Dec 30 1897**

21. I hereby certify that I attended the deceased from **Oct 24**, 19**39**, to **May 2**, 19**39**  
that I last saw him alive on **May 2** and that death occurred on the date and hour stated above.  
Immediate cause of death **Pelvic Abscess; Colonic Pneumonia**

8. AGE: Years **41** Months **10** Days **2** If less than one day hr. min.

Due to **199B**

9. Birthplace **MO**

Due to

10. Usual occupation **Housewife**

Other conditions **Chronic Myelomon.**

11. Industry or business

Major findings: **None**

12. Name **Joe Martin**

Of operations

13. Birthplace **MO**

Of autopsy **None**

14. Maiden name **Missie Buck**

22. If death was due to external causes, fill in the following:

15. Birthplace **MO**

(a) Accident, suicide, or homicide (specify)

16. (a) Informant's own signature **Record Clerk**

(b) Date of occurrence

(b) Address **ITC Gen Hospt**

(c) Where did injury occur? (City or town) (County) (State)

17. (a) **Burial** (b) Date thereof **Jun 4 39**

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(c) Place: burial or cremation **Elmwood**

While at work? (Specify type of place) (e) Means of injury

18. (a) Signature of funeral director **Mrs. C. F. Guster**

23. Signature **P. H. De. Manna**

(b) Address **918 Broadway, Mo. K.C. Mo**

**Sept. 10 Gen Hospt**

19. (a) (Date received local registrar) (b) (Registrar's signature) **M. H. Crowe**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39  
U.S. GPO

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.

MOTHER FATHER

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed C. H. Wise

Licensed Embalmer No. 2570

P. O. Address 918 Brooklyn

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**