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5-42
17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 1 1943

Registration District No. 337

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4497

State File No. 3703

Registrar's No. 2

1. PLACE OF DEATH:
(a) County Shelby
(b) City or town Clarence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓ (Specify whether
In this community all his Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 102
(a) State (b) County 0
(c) City or town 0
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME James Charles Ridge
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Male
5. Color or race C
6. (a) Single, widowed, married, divorced ✓ 9
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased Jan (Month) 11 (Day) 1861 (Year)

8. AGE: Years 81 Months 11 Days 5 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name Dont Know
13. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know 9 (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-42 (Month) (Day) (Year)
(c) Place: burial or cremation Clarence
18. (a) Signature of funeral director E E Hopper
(b) Address Clarence Mo
19. (a) Jan. 28-43 (Date received local registrar) (b) Madge Gooch (Registrar's signature)

1095

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 16
year 1942 hour 1, minute P M.
21. I hereby certify that I attended the deceased from
Dead when seen, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Acute Myocarditis | |
| Due to Senility | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations 93 | |
| Of autopsy | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature Frank K. Roy (M. D. or other)
Address Clarence Date signed 12-22-42

(Licensed Embalmer's Statement on Reverse Side)

FEB 3 1943

DEC 29 1952

RECEIVED
District Health Officer No. 19
District File Number 1-43-170
Date Filed JAN 28 1943
JAN 28 1943 JAN 28 1943

**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 E. E. Hopper

Licensed Embalmer No. 4260

P. O. Address Lawrence Ind

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

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3703

Registration District No. 337 Primary Registration District No. 4497 Registrar's No. 2

1. PLACE OF DEATH:
(a) County: Shelby
(b) City or town: Clarence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State: Shelby Mo (b) County: Shelby
(c) City or town: Clarence
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: James Charles Ridge
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: B
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Jan (Month) 11 (Day) 1860 (Year)

8. AGE: Years 81 Months 11 Days ..... If less than one day: ..... hr. ..... min.

9. Birthplace: (City, town, or county) ..... Mo. (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
MOTHER FATHER
12. Name .....
13. Birthplace: (City, town, or county) ..... (State or foreign country)
14. Maiden name .....
15. Birthplace: (City, town, or county) ..... (State or foreign country)
16. (a) Informant: Dorothy Ridge
(b) Address: Clarence, Mo
17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....
18. (a) Signature of funeral director .....
(b) Address .....
19. (a) ..... (Date received local registrar) (b) Melge Good (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 16 year 1942 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

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(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ..... (c) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY