

No. 2
M-2-43
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35075

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 108

1. PLACE OF DEATH:

(a) County JOHNSON

(b) City or town WARRENSBURG
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
WARRENSBURG CLINIC
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 HOURS
(Specify whether years, months or days)

In this community 50 YEARS

3. (a) PRINT FULL NAME WILLIAM ISAAC RITNER

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex MALE 5. Color or race CAUC

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife GRACE RITNER alive 70 years

7. Birth date of deceased FEBRUARY 2 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

72 8 29 hr. min.

9. Birthplace LITTLE WASHINGTON PA. 1
(City, town, or county) (State or foreign country)

10. Usual occupation RETIRED MERCHANT

11. Industry or business GROCCER

MOTHER FATHER

12. Name JAMES FRANKLIN RITNER

13. Birthplace UNKNOWN PA. 1
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 9
(City, town, or county) (State or foreign country)

16. (a) Informant GRACE RITNER

(b) Address HOLDEN MISSOURI

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT 12 1943
(Month) (Day) (Year)

(c) Place: burial or cremation HOLDEN, MO

18. (a) Signature of funeral director Canada T. Rogers

(b) Address Holden Mo

19. (a) Oct 8 1943 (Date received local registrar) (b) Seala M. Williams (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JOHNSON

(c) City or town HOLDEN 151
(If outside city or town limits, write "RURAL")

(d) Street No. 5TH AND MARKET
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country XX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 11
year 1943 hour 5 minute A M.

21. I hereby certify that I attended the deceased from June 4, 1943, to Oct 11, 1943, that I last saw him alive on Oct 10, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Sanquine of foot

Due to Thrombo-Angiitis Obliterans

Due to _____

Other conditions Chr. Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 93d

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? _____

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

23. Signature Kelly Rawlins (M. D. or other) _____

Address Holden Mo Date signed 10/14/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8,

District File No.

11-3-43

Date Recd

OCT 1 1945

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 *M J Canaday*.....

Licensed Embalmer No. *3434*.....

P. O. Address *Holden Ma*.....

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, fact should be so stated above.