

FILED FEB 18 1944
149

Registration District No. _____

Primary Registration District No. 100

Registrar's No. 546

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)

In this community 50 years,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. Lucerne Hotel
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME Dr. Caleb Anderson Ritter

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

4. Sex Male 5. Color or Race White

6. (a) Single, widowed, married, 2 divorced Widowed

6. (b) Name of husband or wife Mary Helen Ritter

6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased August 25 1851
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>92</u>	<u>5</u>	<u>6</u>	hr. _____ min. _____

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

10. Usual occupation Retired Physician

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

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

16. (a) Informant Dr. G. Charles Gray

(b) Address 3530 Charlotte, Kansas City, Mo.

17. (a) Burial (b) Date thereof 2-2-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Ellham Plaza, K. C., Mo.

19. (a) 2-2-44 (b) T. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 31st year 1944 hour _____ minute _____ P. M.

21. I hereby certify that I attended the deceased from 1 24 44 to 1 31 44
that I last saw him alive on 1 31 44 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Influenza - Bronchial
Due to Pneumonia virus
suppended

Due to _____

Other conditions Cardiac Failure
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 0

23. Signature T. Brown (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr. C. E. Connerley
Prof. Bledy

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. M. Plank

Licensed Embalmer No. 1848

P. O. Address K. C. Mo

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.