

FILED AUG 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **L25517**Registration District No. **214**Primary Registration District No. **3056**Registrar's No. **159**

1. PLACE OF DEATH:

(a) County **Randolph**
 (b) City or town **Moberly**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
421 Monroe
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME

Martha Rifenberg
 (b) If veteran, name war _____
 3. (c) Social Security No. **490-18-7227**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (c) Age of husband or wife if alive **28th 1913**
 7. Birth date of deceased **Sept. 28th 1913**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
30 9 17 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
 12. Name **Boyd Wright**
 13. Birthplace **Mo**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Iva Gilvin**
 15. Birthplace **Mo**
 (City, town, or county) (State or foreign country)

16. (a) Informant **John C. Rifenberg**

(b) Address **Moberly**

17. (a) **Burial** (b) Date thereof **July 18th 44**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Moberly Mo**

18. (a) Signature of funeral director **Mahon and Son**

(b) Address **Moberly Mo**

19. (a) **7-18-44** (b) **Irma Havel**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Randolph**
 (c) City or town **Moberly**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **140 Thompson**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **15th**
 year **1944** hour **12** minute **05** P.M.

21. I hereby certify that I attended the deceased from **July 7, 1944**
 to **July 15, 1944**
 that I last saw her alive on **July 13, 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Paracarditis** Duration **3da**
 Due to **Acute Paratyphoid** **8da**

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: **10512**
 Of operations _____
 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?

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

23. Signature **Rev. S. Jolly** (M.D. or other) **20**
 Address **203 1/2 N. Black St. Moberly** Date signed **7-18-44**

RECEIVED

District Health Officer No.

District File Number 8-44-

Date Filed AUG 8 1944

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.....

Frank D. Witt

Licensed Embalmer No. 3021

P. O. Address.....

Moberly

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Aug
Registrar's No. 1598

Registration District No. 294

Primary Registration District No. 3056

1. PLACE OF DEATH: Randolph
(a) County Moberly
(b) City or town Moberly
(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 _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Martha Ripenberg
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased: Sept 28
(Month) (Day) (Year)

8. AGE: Years 30 Months 9 Days 7 (If less than one day _____ min.)

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

10. Usual occupation Office Clerk

11. Industry or business Key. S. Jolly, D.O.

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 _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Mabel & Son Moberly Mo.

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1955 hour 9 minute 45 M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

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.

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 _____ (M. D. or other)

Address _____ Date signed _____

MOTHER FATHER

SUPPLEMENTARY

25517