

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 380

Primary Registration District No. 6288

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Foreign Birth
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Died on way to hospital between Grove Spring & Lebanon
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Lebanon
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Wright
(c) City or town Grove Spring Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country unknown

3. (a) PRINT FULL NAME Steara Riffenberg

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Bessie Riffenberg 6. (c) Age of husband or wife if alive 35 years
7. Birth date of deceased Aug 10 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>3</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name unknown
13. Birthplace Foreign
(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 Bessie Riffenberg
(b) Address Grove Spring MO
17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Little Vine

18. (a) Signature of funeral director Palmer Funeral Home
(b) Address Lebanon MO
19. (a) Oct 30 1945 (b) Dora Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 13
year 1945 hour 4 minute P 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.

Immediate cause of death Ruptured appendix

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) 20 Hough

Major findings: _____
Of operations _____
Of autopsy _____

Duration 12 1/2
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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 _____

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

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.....

.....
Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 380

Primary Registration District No. 6288

1. PLACE OF DEATH:

(a) County Wright Union Township
(b) City or town Grave Springs rural
(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 Stearl Riffenberg

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 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 _____

7. Birth date of deceased Aug 10 1945
(Month) (Day) (Year)

8. AGE: Years 47 Months 3 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 Palmer undertaker

(b) Address Lepson, Mo.

17. (a) _____ (b) Date thereof Oct 20 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Dora Jones
(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 Oct Day 20 Year 1945 Hour _____ Minute _____ 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 _____

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

SUPPLEMENTARY

34991