

**FILED NOV 17 1945** STANDARD CERTIFICATE OF DEATH

State File No. **37733**

Registration District No. **170**

Primary Registration District No. **5630**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County **Laclede**  
(b) City or town **Lebanon 5 mi E. 66 Highway**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Lebanon**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1** (Specify whether  
In this community \_\_\_\_\_ years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Dallas**  
(c) City or town **Beffers Rural**  
(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 **Paul K. RITCHEMEYER**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Sept-30-1918**  
(Month) (Day) (Year)

8. AGE: Years **27** Months \_\_\_\_\_ Days **29** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Farmer**

11. Industry or business \_\_\_\_\_

12. Name **Paul Ritchmeyer**

13. Birthplace **Grand Rapids Mich**  
(City, town, or county) (State or foreign country)

14. Maiden name **Jane Bonner**

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

16. (a) Informant **Paul Ritchmeyer**

(b) Address **Beffers Mo**

17. (a) **Buried** (b) Date thereof **Nov-1-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maple Creek**

18. (a) Signature of funeral director **W. Frankberger**

(b) Address **13 Beffers Mo**

19. (a) **Oct 30, 1945** (b) **Paul K. Frankberger**  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Oct** day **28**  
year **1945** 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.

Immediate cause of death **Fractured Skull**

Due to **Auto Accident**

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(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) **Accident 53**

(b) Date of occurrence **Oct 28 1945**

(c) Where did injury occur? **5 MI. EAST LEBANON LACLEDE MO**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**U.S. Highway # 66**

While at work? **No** (Specify type of place)

(e) Means of injury **3**

23. Signature **W. Frankberger** (M. D. or other)

Address **Lebanon Mo** Date signed **10/28/45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

Received .....  
Laclede County Health Unit  
File No. 10-45-151 .....  
Date Filed 11/15/45 .....

NOV 16 1957

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 *Lemuel B. Jones* .....

Licensed Embalmer No. 2508 .....

P. O. Address *Buffalo 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. \_\_\_\_\_

Registration District No. 170 Primary Registration District No. 5630

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

1. PLACE OF DEATH:  
(a) County Laclede  
(b) City or town Lebanon Twp Rural  
(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 Paul K. Ritzmeyer  
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 s  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Sept 30 (Month) (Day) (Year)

8. AGE: Years 27 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

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 \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(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 10 day 28 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. (Immediate cause of death)

Due to HEAD ON COLLISION WITH A TRUCK

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 9 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) ACCIDENT  
(b) Date of occurrence OCT 28 1945  
(c) Where did injury occur EAST OF LEBANON LACLEDE MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ON U.S. #66

While at work? No (Specify type of place) (e) Means of injury CAR COLLISION

23. Signature R. Palmer (CORONER (M. D. or other) \_\_\_\_\_ Address Lebanon Date signed 11/2/45

**SUPPLEMENTARY**

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

37733