

S. No. 2
DM-5-43
v. 5-17-39
P I X36671

FILED FEB 11 1947
Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 439

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

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 hrs. 59 min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Lail Ritter

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female **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 January 28 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			<u>2 hr. 59 min.</u>

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

10. Usual occupation infant

11. Industry or business _____

12. Name James Low Ritter

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

14. Maiden name Lucille Schalk

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

16. (a) Informant James Low Ritter

(b) Address 711 W. 75th Kansas City, Mo.

17. (a) Removal Removal **(b) Date thereof** 1-29-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lenexa Kansas

18. (a) Signature of funeral director Wilbur H. Hoag

(b) Address Oakland Park Kansas

19. (a) 1-29-47 **(b) A. Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 711 W 75th Street 5
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1947 hour 6 minute 08 P.M.

21. I hereby certify that I attended the deceased from Jan. 28
1947 to Jan. 28 1947

that I last saw her alive on Jan. 28 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Prematurity

Due to 6 months pregnancy

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations: _____ 159

Of autopsy: _____

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)

(2) Means of injury _____

23. Signature Eugene H. Ferguson (M. D. or other) M.D.

Address 233 Prof Bldg **Date signed** 1-28-47

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.