

DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS  
 FILED APR 20 1947

 THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

13640

State File No. ....

Registration District No. 149Primary Registration District No. 1002Registrar's No. 1617

## 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: VINEYARD HOSPITAL  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 11 HOURS  
 In this community KANSAS CITY 5 1/2 years  
 years, months or days (Specify whether)

## 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. 709 E 5TH STREET 8  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country
3. (a) PRINT FULL NAME CHARLES RIBASTE
 3. (b) If veteran, name war No  
 3. (c) Social Security No. 496-16-3537

 4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced WIDOWED

 6. (b) Name of husband or wife MRS. AVESTA RIBASTE  
 6. (c) Age of husband or wife if alive 49 1/2 years

 7. Birth date of deceased SEPTEMBER 21 1895  
 (Month) (Day) (Year)

 8. AGE: Years Months Days If less than one day  
51 7 6 28  
 hr. min.

 9. Birthplace KANSAS CITY MISSOURI  
 (City, town, or county) (State or foreign country)
10. Usual occupation PRODUCE DEALER

## 11. Industry or business

 MOTHER FATHER  
 12. Name JOHN RIBASTE  
 13. Birthplace UNKNOWN ITALY  
 (City, town, or county) (State or foreign country)  
 14. Maiden name LOTISHA PIAGE  
 15. Birthplace UNKNOWN ITALY  
 (City, town, or county) (State or foreign country)
16. (a) Informant Peter Ribaste(b) Address 709 E. 5th St.
 17. (a) BURIAL (b) Date thereof 4-10-47  
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation MT. ST. MARY'S CEMETERY18. (a) Signature of funeral director D. H. Williams(b) Address 1401 BRUSH GREEN BLDG.
 19. (a) 4-8-47 (b) Sheraldine Holmes  
 (Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

 20. DATE OF DEATH: Month APRIL day 7th  
 year 1947 hour 12:15 minute A M.

 21. I hereby certify that I attended the deceased from 4-4-47  
 to 4-7-47  
 that I last saw him alive on 4-7-47  
 and that death occurred on the date and hour stated above.

 Immediate cause of death Lobar pneumonia Duration 5 days
Due to influenza + Bronchitis

Due to

Other conditions (include pregnancy within 3 months of death)

 Major findings: Of operations 33

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

23. Signature D. H. Williams (M. D. or other)Address 925 Argyle Bldg Date signed 4-7-47

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

925  
11:30-5/30

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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.....

*John C. Making*....., Registered Apprentice No. *504*  
working under my personal supervision.

Signed *C. Oscar Kothey*.....

Licensed Embalmer No. *1767*.....

P. O. Address *Kansas City*.....

**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.**