

FILED MAY 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **16797**

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>162</u>		
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>			c. LENGTH OF STAY (In this place) <u>28 Days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cole Camp</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bothwell Memorial</u>				d. STREET ADDRESS (If rural, give location) _____				
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Ina</u>	b. (Middle) <u>None</u>	c. (Last) <u>ricken</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 17th 1949</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 14th 1880</u>		9. AGE (In years last birthday) <u>69</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Theatre</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Witsom</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>George ricken</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>496-26-4044</u>		17. INFORMANT'S SIGNATURE OR NAME <u>George ricken</u>		ADDRESS <u>Cole Camp Mo</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphosarcomatosis, generalized.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					<u>2001</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>June 15, 1946</u> , to <u>5-17, 1949</u> , that I last saw the deceased alive on <u>5-16-</u> , 1949, and that death occurred at <u>3:15A m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____			23b. ADDRESS <u>312 1/2 S. Ohio St., Sedalia, Mo.</u>			23c. DATE SIGNED <u>5-17-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5-19-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cole Camp Memorial</u>		24d. LOCATION (City, town, or county) (State) <u>Cole Camp Mo.</u>			
DATE REC'D BY LOCAL REG. <u>5-17-49</u>		REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Cole Camp Mo</u>		

MAY 24 REC'D

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 5-24-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed E. L. Eichhoff

Licensed Embalmer No. 730

P. O. Address Cole Camp 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.