No. 300
10.48

FILED MAY 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11166

BIRTH NO. _____ REG. DIST. NO. 20 PRIMARY REG. DIST. NO. 5081 Registrar's No. 91

1. PLACE OF DEATH
a. COUNTY: Bates
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-East Boone Twp
c. LENGTH OF STAY (in this place): 30 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Bates
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-East Boone Twp.
d. STREET ADDRESS (If rural, give location): 0070

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Henry
c. (Last): Ritter

4. DATE OF DEATH (Month) (Day) (Year): May 1, 1954

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 23, 1869
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months 7, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Cass Co. Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Samuel Ritter
13b. MOTHER'S MAIDEN NAME: Sarah Gulick
14. NAME OF HUSBAND OR WIFE: Sarah Elizabeth Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: W.T. Ritter, Adrian Mo.

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) Pulmonary Embolii — INTERVAL BETWEEN ONSET AND DEATH: 1 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Colon — 1 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 153 X
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, 1954, *to* May 1, 1954, *that I last saw the deceased alive on* May 1, 1954 *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: D.S. Colson
(Degree or title): DO
23b. ADDRESS: Adrian Mo
23c. DATE SIGNED: May 1 1954

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5-2-54
24c. NAME OF CEMETERY OR CREMATORY: Crescent Hill Cem.
24d. LOCATION (City, town, or county) (State): Adrian Mo.

DATE REC'D BY LOCAL REG.: 5-2-54
REGISTRAR'S SIGNATURE: Myra Crouch
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lily Funeral Service Adrian Mo

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3250

P. O. Address Adrian Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.