

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-000773
STATE FILE NUMBER

FILED JAN 15 1959

Registration District No. 100 Primary Registration District No. Registrar's No. 117

300
1-57

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bunker		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Bunker
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb 40 yrs	d. STREET ADDRESS (If outside, give location) --
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Henry Ritter			4. DATE OF DEATH Month Day Year Jan 1 1959
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY timber	9. AGE (In years (at birthday)) 81
11. BIRTHPLACE (City and state or country) Shannon Co Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Ike Ritter		13b. MOTHER'S MAIDEN NAME Betsy Ann Ritter	14. NAME OF HUSBAND OR WIFE Nancy Pankev Ritter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. X	17. INFORMANT Address Lawrence Ritter Bunker Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>incontinence</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Senility</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 794X			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>12-26-58</u> <u>12-26-58</u> and last saw ^{her} alive on <u>12-26-58</u> Death occurred at <u>2:15</u> A <u>3</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, free or title) <i>Blenn Newman D.O.</i>		22b. ADDRESS <i>Centerville Mo. 1-5-59</i>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Jan 4 1958	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem	23d. LOCATION (City, town, or county) (State) Salem Mo
24. FUNERAL DIRECTOR Spencer Funeral Home Inc		25. DATE RECD. BY LOCAL REG. 1/7/59	26. REGISTRAR'S SIGNATURE <i>M. M. Nash, M. D. L. M.</i>

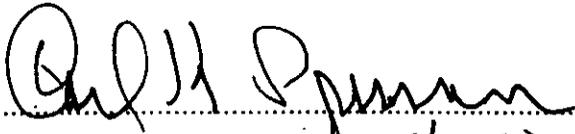
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.