

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-006518**

**FILED VS FEB 23 1960**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 807 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>JACKSON</u>	a. STATE <u>Mo</u>	b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>	Length of stay in 1b <u>20 YRS.</u>	c. CITY OR TOWN <u>KANSAS CITY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital #</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7430 CHESTNUT</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Walter T</u>	Middle <u>RITTER</u>	Last <u></u>	4. DATE OF DEATH	Month <u>2</u>	Day <u>8</u>	Year <u>60</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1897</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>THOS. A. RITTER Co.</u>	11. BIRTHPLACE (City and state or country) <u>Indep. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Thomas Ritter</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>HILMA @ RITTER</u>
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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>496-05-2391</u>	17. INFORMANT <u>HILMA RITTER, 7430 CHESTNUT KEMO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute pulmonary edema</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days.
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY	Hour _____	Month, Day, Year _____
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20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from 1-30-1960 to 2-8-1960 and last saw him alive on 2-8-1960  
 Death occurred at 3:15 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. Dwyer</u> (Degree or title)	22b. ADDRESS <u>2400 Perry St</u>	22c. DATE SIGNED <u>7/9/1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2-10-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FLORAL HILLS CEM.</u>	23d. LOCATION (City, town, or county) <u>KANSAS CITY, Mo.</u>
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24. FUNERAL DIRECTOR <u>Geo. C. CARSON &amp; SONS, INDEP. Mo.</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>2-10-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. Dwyer

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Wm. H. Carter

Licensed Embalmer No. 5087

P. O. Address Indy, Ind.

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.