

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-014304

FILED VS MAY 16 1960

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 548 STATE FILE NUMBER

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Buchanan</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Length of stay in 1b <u>Life</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>301 Harvard St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 2</u>				d. STREET ADDRESS (If outside, give location) <u>301 Harvard St.</u>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. AGE (last birthday)	
First <u>JOSEPH</u>		Middle <u>A.</u>		Last <u>RITTER</u>		Month <u>May</u> Day <u>10,</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1890</u>	9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>August C. Ritter</u>		13b. MOTHER'S MAIDEN NAME <u>Rose McLarney</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records State Hospital # 2 St. Joseph, Mo.</u> Address			
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>Aspiration of Vomitus</u>						<u>15 Min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Gastric ulcer. bleeding known 6 wks.</u>							
DUE TO (c) <u>Unknown cause</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gangrene R. leg known 6 w.</u>						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.	
<u>Anemia, Jaundice 2-3 days Schizophrenia, hebephrenic 1927</u>							
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.)			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____		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	
21. I attended the deceased from <u>O.D. on date patient died and never seen alive</u> and his last few <u>11</u> <u>days</u> lived on. (Death occurred at <u>10:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Mary L Ames M.D.</u>				22b. ADDRESS <u>St. Joseph, Missouri</u>		22c. DATE SIGNED <u>5-10-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 13, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>	
24. FUNERAL DIRECTOR <u>H.O. Schuyler & Son R.A.Y.</u> ADDRESS <u>St Joseph, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>May 12, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Wm. Clark Handell</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Robert D. Gyle

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.