

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-014753

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 50

FILED MAY 10 1961

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft Leonard Wood, Mo.</u>		Length of stay in 1b	c. CITY OR TOWN <u>Leasburg</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>US Army Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>VERL</u> Middle <u>ALLEN</u> Last <u>RICKETTS, Jr</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1961</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>7 Nov 60</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>	IF UNDER 24 HR Hours <u>13</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ft Sam Houston, Texas</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Verl Allen Ricketts, Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Barbara Luire Hodapp</u>		14. NAME OF HUSBAND OR WIFE	
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.		17. INFORMANT <u>Barbara L. Ricketts, Leasburg, Mo.</u>	
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>Subarachnoid Hemorrhage</u>					
DUE TO (b) <u>Interstitial Pneumonia</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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. 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>19 April 1961</u> to <u>19 April 1961</u> and last saw ^{him} <u>him</u> alive on <u>19 April 1961</u> Death occurred at <u>10:45 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Thomas E. Dillon M.D.</u> (Degree or title) <u>THOMAS E. DILLON, Captain, MC</u>			22b. ADDRESS <u>US Army Hospital</u> <u>Fort Leonard Wood, Missouri</u>		22c. DATE SIGNED <u>19 Apr 61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Apr. 19 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lea Cuba Mo.</u>		23d. LOCATION (City, town, or county) <u>Leasburg Mo.</u>	(State)
24. FUNERAL DIRECTOR <u>Hoener Funeral Home</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-19-61</u>	26. REGISTRAR'S SIGNATURE <u>Eula Mae Anderson</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 Norman C. Haenes

Licensed Embalmer No. 4673

P. O. Address Cuba, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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