

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-041936

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 191

FILED NOV 26 1962

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Austin Township</u>		Length of stay in lb <u>none</u>	c. CITY OR TOWN <u>Adrian</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>U. S. Highway # 71</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONARD L. RITTER</u>			4. DATE OF DEATH Month Day Year <u>November 18, 1962</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>Sept 5, 1922</u>	9. AGE (last birthday) <u>40</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	11. BIRTHPLACE (City and state or country) <u>Bates County, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William Ritter</u>	13b. MOTHER'S MAIDEN NAME <u>Pearl Blackman</u>	14. NAME OF HUSBAND OR WIFE <u>Marine Ritter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WW # 2</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>W. T. Ritter Adrian, Missouri</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u>
DUE TO (b) <u>Brain Laceration</u>		
DUE TO (c) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto accident</u>
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20c. TIME OF INJURY Hour a.m. <u>5:40</u> Month, Day, Year <u>11-18-62</u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>71 Hwy 5 1/2 hrs S of</u>	20f. CITY, TOWN, OR LOCATION <u>Hannibal</u>	COUNTY <u>Cass</u>	STATE <u>Mo</u>
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21. I attended the deceased from _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <u>Stem Cummins Cass Co Coroner</u>	21b. ADDRESS <u>Hannibal Mo.</u>	21c. DATE SIGNED <u>11-18-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/19/1962</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Crescent Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Adrian, Missouri</u>
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24. FUNERAL DIRECTOR <u>Six Funeral Service</u>	ADDRESS <u>Adrian, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>11-20-62</u>	26. REGISTRAR'S SIGNATURE <u>Robert J. DeBree</u>
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DO NOT WRITE ON THIS STUB
 AMENDED
 DATE AMENDED
 10190
 20070
 3
 4 0
 5 1
 6
 7 0
 8 2
 9 X
 10
 11019
 1291-3
 132-0
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 USE BLACK INK OR TYPEWRITER RIBBON

NOV 28 1962
DEC 19 1962

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 *Robert W. Walker*

Licensed Embalmer No. 4902

P. O. Address *Harlem, Va.*

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.