

FILED MAR 14 1941 99

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 774

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)
In this community 30 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas Cmty
(If outside city or town limits, write "RURAL")
(d) Street No. 2525 Norton
(If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Eva Ritter

3. (b) If veteran, name was No 3. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Harry E. Ritter 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Nov. 9, 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 3 Days 12 If less than one day hr. _____ min. _____

9. Birthplace Ft. Leavenworth Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

12. Name Edwin Edward

13. Birthplace England
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Peal

15. Birthplace Trenton New Jersey
(City, town, or county) (State or foreign country)

16. (a) Informant Harry E. Ritter

(b) Address 2525 Norton

17. (a) Burial (b) Date thereof Feb. 24, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 7/22/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21st
year 1941 hour 8 minute 15 A.M. M.

21. I hereby certify that I attended the deceased from 2-16-41 19____ to 2-21-41 19____
that I last saw her alive on 2-21-41 19____
and that death occurred on the date and hour stated above.

Immediate cause of death acute bilateral auricular dilatation with aneurysm of left auricular appendage associated with thrombosis, mitral valvulitis
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy See above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ (Specify type of place) _____
While at work? _____ Means of injury 1
23. Signature Dr. R. P. Thon (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital, K. C. Mo. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

4218-

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Gerald J. Wade

Licensed Embalmer No. 4172

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

2B
-40
2265

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

EVNA MOORE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 6002
Registrar's No. 774

Registration District No. Primary Registration District No.

1. PLACE OF DEATH
(a) County Jackson
(b) City or town N.C.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME Eva Ritter
(b) If veteran, name war (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive year

7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years Months Days If less than one day
52 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2/22/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

20. DATE OF DEATH Month Feb day 21 year 41
hour minute M.
21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death Acute, Bilat. Arricular dilatation
Arteriosclerosis associated
with atherosclerosis, mitral
valvulitis.
Due to
Due to
Other conditions (include pregnancy within 3 months of death)
Undetermined - Negative Serology
Major findings:
Of operations
Of autopsy
Duration
PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTAL

S-6002