

FILLED OCT 13 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30847
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Knox Primary Registration District No. 100
(c) City Kansas City (d) Street No. Wesley Court Registered No. 3605
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Grace Ritter St. Odessa, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Ritter

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1, 1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 8 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lexington, Mo.

FATHER 13. NAME James Frammel

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland

MOTHER 15. MAIDEN NAME Mary Peaches

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) John Ritter
Odessa Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Odessa Mo. DATE 9/28

19. FUNERAL DIRECTOR (NAME) (ADDRESS) F. C. Husman
Odessa Mo.

20. FILED 9/28, 19 41 Mo. Mo. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sep 28, 19 41

22. I HEREBY CERTIFY, That I attended deceased from Sep 25, 1941, to Sep 28, 1941
I last saw him alive on sep 28, 1941. Death is said to have occurred on the date stated above, at 7 P. m.
The principal cause of death and related causes of importance were as follows:

maningeal
suppuration
(not contagious)
81a

Other contributory causes of importance:
Streptococci
infection
(not contagious)

Name of operation no Date of no
What test confirmed diagnosis? laboratory Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury no, 19 no
Where did injury occur? no (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. no

Manner of injury no
Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify no
(Signed) J. T. Mustkey M. D.
(Address) Kansas City, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 20 1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30847
Registrar's No. 3655

Registration District No. 399

Primary Registration District No. 1002

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME Grace Ritter

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

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Jan 1, 1880
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 28 If less than one day 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) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 9-28-41 (b) MM Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette
(c) City or town Odessa
(If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28 year 1941 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19.....
that I have a lawfully license to practice medicine in this State, and that death occurred on the date and hour stated above.
Immediate cause of death.....

Duration

Due to.....
Due to.....
Other conditions..... (Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?
While at work?..... (Specify type of place) (e) Means of injury.....

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

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

MOTHER FATHER

SUPPLEMENTARY

1941

S-30847