

FILED NOV 17 1941

Registration District No. **197**

Primary Registration District No. **5276**

Registrar's No. **54**

1. PLACE OF DEATH:

(a) County **Clay**
(b) City or town **Gashland**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **None**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **16 Years**
In this community **16 Years**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clay**
(c) City or town **Gashland**
(If outside city or town limits, write "RURAL")
(d) Street No. **None**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Dr. Philip Ritter**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. Frances Ritter** 6. (c) Age of husband or wife if alive **61** years

7. Birth date of deceased **February 24 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 **7** **27** hr. min.

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

10. Usual occupation **Veterinarian**

11. Industry or business **For Self**

12. Name **George Ritter**

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

14. Maiden name **Unknown**

15. Birthplace **Red Bud Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss Frances Ritter**

(b) Address **Gashland Mo**

17. (a) **Burial** (b) Date thereof **Oct. 25, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial, cremation **Brenner Ridge Cemetery**

18. (a) Signature of funeral director **D. H. Newcomer, Sona**
(b) Address **Kansas City, Missouri**

19. (a) **10-24-41** (b) **Paul W. Henry**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **23rd**
year **1941** hour **12** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Feb. 10**
1941 to **Oct. 23** **1941**
that I last saw him alive on **Oct. 23** **1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary heart failure, due to Hypertension & Dropsy.**

Due to **Atherosclerosis, + Hypertension.**

Due to **Chronic Interstitial nephritis.**

Other conditions **Oedema + Urinary retention**
(Include pregnancy within 5 months of death)

Major findings: **due to prostatic obstruction**

Of operations **none**

Of autopsy **none** **B/a**

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? **-**

(e) Means of injury **-** (Specify type of place)

23. Signature **P. G. Jennings** (M. D. or other) **MD**
Address **Gashland, Mo** Date signed **10-24-41**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 11-13-41.....

9-5-
O. O. [unclear]
Haskell and [unclear]

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

Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address Ke 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 this body is not embalmed, fact should be so stated above.