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M-2-43  
5-17-33  
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FILED JUN 24 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2506

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
General Hospitel  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3/23/43 To 5/31/43  
(Specify whether years, months or days)

In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. 523 Grand Ave. Helping Hand  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country None

3. (a) PRINT FULL NAME Fred Duane Ritter

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased unknown  
(Month) (Day) (Year)

8. AGE: 72 Years Months Days If less than one day  
hr. min.

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

10. Usual occupation Sardis

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Seri Ritter

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

14. Maiden name Hartsock

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

16. (a) Informant D. C. A. Ritter

(b) Address 911 Sanwood Blvd

17. (a) Cremation (b) Date thereof June 2 - 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elanwood

18. (a) Signature of funeral director Pres. ...

(b) Address Kansas City Mo.

19. (a) 6-2-43 (b) M. M. Grome  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31  
year 1943 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_  
that I last saw h Deputy Coroner \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Embolus  
Right Iliac  
Thrombosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: Fractured Hip  
(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) Pending investigation

(b) Date of occurrence Jan 20 - 1943

(c) Where did injury occur Kansas City Jackson Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes

While at work No (Specify type of place) (e) Means of injury Unknown

23. Signature D. C. A. Ritter (M. D. or other) M.D.  
Address 2212 McWay Date signed 6/2/43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

361

RECORD

**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 Park Y Rowe

Licensed Embalmer No. 2347

P. O. Address K. C. 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.**

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 25-06

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kennett 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 Fred W. Ritter  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Date received local registrar) \_\_\_\_\_ (b) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 31  
year 1943 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.  
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) Accident  
(b) Date of occurrence Dec. 30, 1942  
(c) Where did injury occur? Kennett City Jackson Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? No (Specify type of place) \_\_\_\_\_ (Specify type of injury) Trauma

23. Signature A. E. Upsher (M. D. or other) M.D.  
Address 23rd McRay Date signed 10/28/43

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

SUPPLEMENTARY

20584