

FILED SEP 13 1945
Registration District No. 132

Primary Registration District No. 5476

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

1. PLACE OF DEATH:

(a) County Grundy
(b) City or town Linsdon Township
(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.....
In this community 79-4-1 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Grundy
(c) City or town Rural
(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.....

3. (a) PRINT FULL NAME Charles Stone Ricketts

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Kate Ricketts 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased April 17 1886
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 1 If less than one day hr. min.

9. Birthplace Grundy Co Mo. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business
12. Name Thomas Ricketts
13. Birthplace Ky. 1
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Taylor
15. Birthplace Ky. 1
(City, town, or county) (State or foreign country)

16. (a) Informant Kate Ricketts
(b) Address Trenton Mo RFD 1

17. (a) Burial (b) Date thereof Aug 19 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Egan Cem Grundy Co Mo

18. (a) Signature of funeral director Spickard

(b) Address Spickard Mo

19. (a) Aug. 22, 45 (b) L. S. Roberts
(Date reported local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 18
year 1945 hour 4 minute 15 A.M.

21. I hereby certify that I attended the deceased from Aug 18 1945
to Aug 18 1945
that I last saw him alive on Aug 16 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-Renal Disease
Hypertrophy of Prostate
Due to..... Duration few years

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?.....

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

23. Signature G. H. Mullers M.D. (M. D. or other)
Address Trenton Mo Date signed 8-18-45

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..... *Cross Wise*
Licensed Embalmer No. *3971*
P. O. Address *Spickard 7/0*

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.