

FILED NOV 25 1946  
324

State File No. \_\_\_\_\_  
Registrar's No. 188

Registration District No. \_\_\_\_\_ Primary Registration District No. 6092

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Grand Pass  
(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 60 yrs " (Specify whether  
years, months or days) RITCHHART

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Saline

(c) City or town Grand Pass  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME PHILLIP HENDERSON RITCHHART

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 married

6. (b) Name of husband or wife They Mae Ritchhart 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Oct-3-1868  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>25</u>	hr. _____ min. _____

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

10. Usual occupation Retired Farmer

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

12. Name Benjamin Ritchhart

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

14. Maiden name Emma Oliver

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

16. (a) Informant Mrs P H Ritchhart

(b) Address Grand Pass mo

17. (a) Burial (b) Date thereof Oct 30 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Pass mo

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) 11/1/46 (b) M. O. Westhok  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28  
year 1946 hour 1 minute 20 P M.

21. I hereby certify that I attended the deceased from 10-24- 1946 to 10-28 1946  
that I last saw him alive on 10-24 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE Duration 4 DAYS

Due to HYPERTENSION ?

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 0

23. Signature Geo. Welling (M. D. or other) \_\_\_\_\_

Address Waverly MO Date signed 11-1-46

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

MOTHER FATHER

29K

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

11-23-46

OCT 21 1946

THAN

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall, 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.