

FILED AUG 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23604

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3131</u>			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>30 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>612 W. 40 St.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>General Hospital No. 1</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 18 1949</u>					
3. NAME OF DECEASED a. (First) <u>Lucy</u>		b. (Middle) <u>M.</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 27, 1888</u>		9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Don't Know</u>		13b. MOTHER'S MAIDEN NAME <u>Don't Know</u>		14. NAME OF HUSBAND OR WIFE <u>Philip H. Ritchhart</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Hyland E. Moore, 612 W. 40th. St.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Miliary tuberculosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		0192			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____							
22. I hereby certify that I attended the deceased from <u>July 16, 1949</u> , to <u>July 18, 1949</u> , that I last saw the deceased alive on <u>July 18, 1949</u> , and that death occurred at <u>12:50 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Wm. W. Hart M.D.</u> (Degree or title)				23b. ADDRESS <u>Med. Dir. Gen'l Hosp.</u>		23c. DATE SIGNED <u>7-19-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-20-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		24d. LOCATION (City; town, or county) (State) <u>Kansas City, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>7-19-49</u>		REGISTRAR'S SIGNATURE <u>Braldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Freeman Mortuary, Kansas City, Mo.</u>					

(Licensed Embalmer's Statement on Reverse Side)

Dr. [Signature]

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.....

Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed.....

[Signature]

Licensed Embalmer No.

2939

P. O. Address.....

F. O. [Signature]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.