

FILED NOV 29 1950

STANDARD CERTIFICATE OF DEATH

5637 State File No. 37607

BIRTH NO. REG. DIST. NO. 171 PRIMARY REG. DIST. NO. 5627 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Lafayette</i>		2. USUAL RESIDENCE (Where deceased lived) If institution: residence before death a. STATE <i>Mo</i> b. COUNTY <i>Lafayette</i>	
b. CITY (If outside corporate limits, write RURAL and give township) <i>Bates City</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>Bates City</i>	
c. LENGTH OF STAY (in this place) <i>7 yrs</i>		d. STREET ADDRESS (If rural, give locality) <i>0540</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Howard</i> b. (Middle) <i>Frank</i> c. (Last) <i>Ring</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Nov-22-1950</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct-25-1867</i>
9. AGE (In years last birthday) <i>83</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>	11. BIRTHPLACE (State or foreign country) <i>Indiana</i>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>

13a. FATHER'S NAME <i>Stephen Ring</i>	13b. MOTHER'S MAIDEN NAME <i>Melba Cooper</i>	14. NAME OF HUSBAND OR WIFE <i>Eva Ring</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS. <i>Mrs Eva Ring Bates City Mo</i>

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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cellulitis of neck, Right.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs.</i>
	ANTECEDENT CAUSES DUE TO (b) <i>Carcinoma of bladder</i>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>180X</i>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan. 1 1940*, to *Nov. 21, 1950*, that I last saw the deceased alive on *Nov. 21, 1950*, and that death occurred at *4 A* m., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>	(Degree or title)	23b. ADDRESS <i>Cablewood Mo.</i>	23c. DATE SIGNED <i>11-22-50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	24b. DATE <i>Nov-28-1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>More Cemetery</i>	24d. LOCATION (City, town, or county) (State) <i>Bates City Mo</i>
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DATE REC'D BY LOCAL REG. <i>Nov. 24-1950</i>	REGISTRAR'S SIGNATURE <i>Emma Davidson Deputy</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Webb Funeral Home. Oak Grove Mo</i>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

540

RECEIVED 11-28-50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 11-28-50

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed R. B. White

Licensed Embalmer No. 2353

P. O. Address Blue Springs, 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.