

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13090**
1661

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 8 Years		d. STREET ADDRESS (If rural, give location) 115 North Askew	
d. FULL NAME OF HOSPITAL OR INSTITUTION 115 North Askew			

3098

3. NAME OF DECEASED (Type or Print) LILLIE B RIDINGER			4. DATE OF DEATH APRIL-10-1952		
a. (First)	b. (Middle)	c. (Last)	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 5-4-1865		9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Abraham Grove		13b. MOTHER'S MAIDEN NAME Catherine Frank		14. NAME OF HUSBAND OR WIFE George Ridinger	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Audria C. Throop ADDRESS 1115 North Askew	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 12 hours
		ANCECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic arteriosclerosis			6 mos
		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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?
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22. I hereby certify that I attended the deceased from April 8, 1952 to April 10, 1952, that I last saw the deceased alive on April 10, 1952, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Chas. S. Nelson (Degree or title) MD		23b. ADDRESS 362 1/2 Independence		23c. DATE SIGNED 4-11-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-12-1952		24c. NAME OF CEMETERY OR CREMATORY	
				24d. LOCATION (City, town, or county) (State) Mountainview, Missouri	

DATE REC'D BY LOCAL REG 4-11-52		REGISTRAR'S SIGNATURE Gertrude Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mrs. C.L. Forster, Kansas City, Missouri	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address Kansas City, 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.