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FILED FEB 23 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3805**

BIRTH NO. _____		REG. DIST. NO. <b>4</b>		PRIMARY REG. DIST. NO. <b>4014</b>		Registrar's No. <b>9</b>		
1. PLACE OF DEATH a. COUNTY <b>ATCHISON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ATCHISON</b>				
b. CITY OR TOWN <b>FAIRFAX</b>		c. LENGTH OF STAY (in this place) <b>3 hrs</b>		c. CITY OR TOWN <b>Rock Port, Mo</b>		0030		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>FAIRFAX COMM. HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>NONE</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b>			b. (Middle) <b>RIDGEWAY</b>		c. (Last) _____		4. DATE OF DEATH (Month) (Day) (Year) <b>2-12-1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>4-9-1912</b>		9. AGE (In years last birthday) <b>42</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AGRICULTURE</b>		11. BIRTHPLACE (State or foreign country) <b>ATCHISON CO. MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		
13a. FATHER'S NAME <b>THOMAS RIDGEWAY</b>			13b. MOTHER'S MAIDEN NAME <b>NANCY OSLIN</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>LON ROBINETTE</b>		ADDRESS <b>Rock Port, Mo</b>		
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>	
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) <b>Arteriosclerosis</b>		10 years		
11. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.				DUE TO (c) _____				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.) _____		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 <b>August, 1954</b> , to <b>2-12-1955</b> , that I last saw the deceased alive on <b>2-12-1955</b> , and that death occurred at <b>1:30A m.</b> , from the causes and on the date stated above.								
23. SIGNATURE (Degree or title) <b>Wallace Carpenter, M.D.</b>				23b. ADDRESS <b>Rock Port, Mo</b>		23c. DATE SIGNED <b>2-14-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>2-14-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>LEWIS CEM.</b>		24d. LOCATION (City, town, or county) <b>Rock Port, Mo</b> (State) _____		
DATE REC'D BY LOCAL REG. <b>Feb 15, 1955</b>		REGISTRAR'S SIGNATURE <b>Norman H. Schaefer</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>BARTHOLOMEW MURPHY</b>		ADDRESS <b>Rock Port, Mo</b>		

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 Grady Buchanan.....

Licensed Embalmer No. 3173.....

P. O. Address Rock Port, 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.