

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18069

State File No. ....

FILED JUN 20 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 73 PRIMARY REG. DIST. NO. 5291 Registrar's No. 47

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Liberty-Rural</u>		c. CITY OR TOWN <u>No. K.C. R#4</u>	
c. LENGTH OF STAY (If this place) <u>2 days</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Odd Fellows Home</u>		STREET ADDRESS (If rural, give location) <u>440 MARTIN Blvd OAKWOOD</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>T.</u> c. (Last) <u>Ricketts</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 15, 1955</u>		
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5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>June 28, 1867</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, or until retired) <u>Farming Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mo. Clay, County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
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13a. FATHER'S NAME <u>John T. Ricketts</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown - GARDNER</u>		14. NAME OF HUSBAND OR WIFE <u>ANNIE Ricketts</u>			
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>FRANK Ricketts</u>				ADDRESS <u>501 Poplar No. K.C. Mo.</u>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho-pneumonia</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senile cerebro-vascular disease</u>						DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		_____						_____	

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 June 12, 1955 to June 16, 1955, that I last saw the deceased alive on June 14, 1955, and that death occurred at 11:35 a.m., from the causes and on the date stated above. •

23a. SIGNATURE (Degree or title) <u>L. O. Schroeder, M.D.</u>		23b. ADDRESS <u>Liberty, Missouri</u>		23c. DATE SIGNED <u>6/16/55</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6-17-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>White Chapel Mem. Hse</u>		24d. LOCATION (City, town, or county) (State) <u>Clay Co. Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>June 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel Graham</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. Newcomers</u>		ADDRESS <u>No. K.C. Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

7 127 W Koen

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.....  
Signature of Student Embalmer

Signed *John M. Kalsbeek*

Licensed Embalmer No. *494*  
P. O. Address *No. Kensa*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.