FILED MAY 9 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14149
STATE FILE NUMBER

Registration District No. 259 Primary Registration District No. 5881 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY OSAGE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY OSAGE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON TWP — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN BELLE, 7760 — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) AT HOME — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) JEFFERSON TWP — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First LAWERENCE Middle LeROY Last RIDENHOUR

4. DATE OF DEATH: Month APRIL Day 30, Year 1956

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 12th, 1934

9. AGE (In years last birthday): 22 — IF UNDER 1 YEAR Months - Days 13 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe factory worker

10b. KIND OF BUSINESS OR INDUSTRY: - Shoe Mfg

11. BIRTHPLACE (City and state or country): Belle, Mo. RT # 1

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHESLEY R. RIDENHOUR

14. MOTHER'S MAIDEN NAME: EMMA MATILDA RUNGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 488-38-3006

17. INFORMANT Address: - Chesley R. Ridenhour. Belle, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute fulminating meningoencephalitis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Ventriculoureteral anastamosis and

DUE TO (c) acute cystitis — 3 day

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic arachnoiditis, adhesive 082X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from June 26, 1955, to April 30, 1956 and last saw him alive on April 30, 1956. Death occurred at 4:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): F. L. Kozal. MD.

22b. ADDRESS: Belle, Mo.

22c. DATE SIGNED: 5-3-56

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: May 4-1956

23c. NAME OF CEMETERY OR CREMATORY: KOENIG CEMETERY

23d. LOCATION (City, town, or county) (State): BELLE, MO. RT # 1

24. FUNERAL DIRECTOR ADDRESS: Clyde Morton MORTON FUNERAL HOME

25. DATE RECD. BY LOCAL REG.: May 5-1956

26. REGISTRAR'S SIGNATURE: [signature]

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....Vernon M. M

Licensed Embalmer No. ...

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.