

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040129

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 722

STATE FILE NUMBER

AMENDED

FILED DEC 4 1961

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Osage</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in 1b <u>64 days</u>	c. CITY OR TOWN <u>Belle</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Missouri Medical Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RAND</u> Middle <u>M.</u> Last <u>Ridenhour</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-1998</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FAAM LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>Osage Co.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>David Ridenhour</u>		13b. MOTHER'S MAIDEN NAME <u>Rebecca Lora</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
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 <u>University of mo. medical records</u> Address _____	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
DUE TO (b) <u>Metastatic Carcinoma</u>		
DUE TO (c) _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Columbia Mo</u>	COUNTY <u>Osage</u>	STATE <u>MO</u>
21. I attended the deceased from <u>9/27/61</u> to <u>11/30/61</u> and last saw ^{him} her alive on <u>11/30/61</u> Death occurred at <u>4:15</u> ^{PM} on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>RE Palmer MD.</u> (Degree or title)	22b. ADDRESS <u>4111C Columbia Mo</u>	22c. DATE SIGNED <u>11-30-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/3/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT Zion</u>	23d. LOCATION (City, town, or county) (State) <u>Lancaster Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>HOWARD JONES</u> ADDRESS <u>BELLE MO.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 1, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs RE Palmer</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

TITLE NO.

100 20 2.4

VS FEB 21 1962

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 *Orin Howard Jones*

Licensed Embalmer No. 4411

P. O. Address Belle Me.

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.