

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-035473
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 217

FILED SEP 30 1963

VS 300
Rev. 4/59

1 6004
2 0930
3
4 1
5 0
6
7 1
8 1
9 331x
10
11
12 6-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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>Platte</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>		Length of stay in 1b <u>10 days</u>	c. CITY OR TOWN <u>Kansas City 53,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.K.C. Memorial Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>T Highway Rt. 23</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Ritter</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1963</u>
5. SEX <u>F</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>8/10/1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>La Crosse, Wis.</u>	9. AGE (last birthday) <u>91</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		11. BIRTHPLACE (City and state or country) <u>La Crosse, Wis.</u>	
13a. FATHER'S NAME <u>Henry Ritter</u>		13b. MOTHER'S MAIDEN NAME <u>Victoria Fischer</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) <u>NO</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>NKC Memorial Hosp. North Kansas City, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331 DUE TO (b) <u>Cerebral Arteriosclerosis</u> 334 DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
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
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 COUNTY STATE	
21. I attended the deceased from <u>1962</u> to <u>death</u> and last saw her alive on <u>9/23/63</u> . Death occurred at <u>1:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. Kimball, MD</u>		22b. ADDRESS <u>6600 Tower Dr. N.W. Kansas City, Mo</u>	22c. DATE SIGNED <u>9/24/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Sept. 25 '63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>La Crosse, Wisconsin</u>
24. FUNERAL DIRECTOR <u>L.H. Francis, 401 Main, Parkville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-24-63</u>	26. REGISTRAR'S SIGNATURE <u>Marquette Hudgens</u>

NOV 1 1961

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 L H Francis

Licensed Embalmer No. 3451

P. O. Address Parkville 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.