

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-048217**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6905

STATE FILE NUMBER

<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <b>JACKSON</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b> Length of stay in lb <b>21 YEARS</b></p> <p>c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>TRINITY LUTHERAN HOSPITAL</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b></p> <p>c. CITY OR TOWN <b>KANSAS CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>4119 FOREST AVENUE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>			
<p><b>3. NAME OF DECEASED</b> First Middle Last <b>Theodore Brown Ridgeway</b></p> <p><b>4. DATE OF DEATH</b> <b>DECEMBER 19, 1963</b></p>			<p><b>5. SEX</b> <b>MALG</b> <b>6. COLOR OR RACE</b> <b>WHITE</b></p> <p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p><b>8. DATE OF BIRTH</b> <b>7-24-1899</b> <b>9. AGE (last birthday)</b> <b>66</b></p>		
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MILK TRUCK DRIVER</b></p> <p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>COUNTRY CLUB DAIRY</b></p>		<p><b>11. BIRTHPLACE</b> (City and state or country) <b>ADNETON CITY, MISSOURI</b></p> <p><b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b></p>		<p><b>13a. FATHER'S NAME</b> <b>JACK RIDGWAY</b> <b>13b. MOTHER'S MAIDEN NAME</b> <b>CELIA WILSON</b></p> <p><b>14. NAME OF HUSBAND OR WIFE</b> <b>DOROTHY RIDGWAY</b></p>	
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)</p> <p><b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>MRS. DOROTHY RIDGWAY - K.C. MISSOURI</b></p>			<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line)</p> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b></p> <p style="text-align: center;">DUE TO (b) <b>Squamous Cell Carcinoma, Left Lung</b> <b>2 years</b></p> <p style="text-align: center;">DUE TO (c)</p> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</b></p> <p><b>PART III. If deceased was female was there a pregnancy in last 90 days.</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>		
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p> <p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>		<p><b>20c. TIME OF INJURY</b> Hour Month, Day, Year</p> <p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p><b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE</p>			
<p><b>21. I attended the deceased from</b> <b>12-17-63</b> to <b>12-19-63</b> and last saw him alive on <b>12-18-63</b></p> <p>Death occurred at <b>9:04 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>			<p><b>22a. SIGNATURE</b> (Degree or title) <b>Richard R. Russell M.D.</b> <b>22b. ADDRESS</b> <b>205 E 63rd St K.C. Mo</b> <b>22c. DATE SIGNED</b> <b>12-19-63</b></p>		
<p><b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>REMOVAL</b> <b>23b. DATE</b> <b>DEC 23 1963</b></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>SUNSET HILLS CEMETERY</b> <b>23d. LOCATION</b> (City, town, or county) (State) <b>WARRENSBURG MISSOURI</b></p>		<p><b>24. FUNERAL DIRECTOR</b> <b>D.W. MURKOWSKI'S Sons - Kansas City, Missouri</b> <b>25. DATE RECD. BY LOCAL REG.</b> <b>12-20-63</b> <b>26. REGISTRAR'S SIGNATURE</b> <b>Bessie Smith</b></p>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SUBSTITUTION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

**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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, Ind.

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.