

S. No. 2  
OM-2.43  
5-17-39  
X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19095  
State File No. \_\_\_\_\_  
Registrar's No. 1314

FILED JUN 7 1943  
Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:  
(a) County St. Louis Co  
(b) City or town Koch  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Robert Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 months 21 days  
(Specify whether \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED: 000  
(a) State Mo (b) County 17  
(c) City or town St. Louis 9  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4633 Minnesota  
(If rural, give location)  
(e) Citizen of foreign country? Mo (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ritzka, Andrew Anthony  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 498-18-9039

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 6 day 2  
year 1943 hour 11 minute 35 A.M.  
21. I hereby certify that I attended the deceased from 1-12-1943 to 6-2-1943  
that I last saw him alive on 6-2-1943  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 2-1-1925  
(Month) (Day) (Year)

Immediate cause of death Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Intestinal Tuberculosis  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
18 4 1 hr. \_\_\_\_\_ min.  
9. Birthplace St. Louis, Mo (City, town, or county) (State or foreign country)  
10. Usual occupation Student MACHINIST

PHYSICIAN  
Major findings: 1381  
Of operations \_\_\_\_\_  
Of autopsy Pulmonary Tuberculosis  
Intestinal Tuberculosis

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Frank William Ritzka  
13. Birthplace Massillon Ohio (City, town, or county) (State or foreign country)  
14. Maiden name Mary Biergler  
15. Birthplace St. Louis, Mo (City, town, or county) (State or foreign country)  
16. (a) Informant Patient  
(b) Address \_\_\_\_\_  
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 5, 1943  
(Month) (Day) (Year)  
(c) Place: burial or cremation SS. PETER AND PAUL CEMETERY  
18. (a) Signature of funeral director Robert Koch Hospital  
(b) Address 2842 Medamore St  
19. (a) JUN 4 1943 (This received local registrar) (b) [Signature] (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Axel Gronau (M. D. or other)  
Address Robert Koch Hospital Date signed 6/3/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....*me*.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Joe D. Benz*

Licensed Embalmer No.....*42119*.....

P. O. Address.....*2847 METAMEC ST.  
ST. LOUIS, 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 this body is not embalmed, fact should be so stated above.**