

No. 9-4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42106

Registration District No. 88
FILED JAN 10 1944

Primary Registration District No. 4151

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Steelville Mo

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community all her life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____ 28

(c) City or town _____ (If outside city or town limits, write "RURAL") 3

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____ 0

3. (a) PRINT FULL NAME Mary Elizabeth Ritcherson

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Burt Ritcherson

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 6-2-1856

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>87</u>	<u>3</u>	<u>1</u>	hr. _____ min.

9. Birthplace Keyville Mo

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business _____

12. Name Samuel A. Stafford

13. Birthplace Keyville Mo

(City, town, or county) (State or foreign country)

14. Maiden name Manda Jane Diversay

15. Birthplace Keyville Mo

(City, town, or county) (State or foreign country)

16. (a) Informant Roberts

(b) Address Waco Mo

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keyville cemetery

18. (a) Signature of funeral director L. J. Jansas

(b) Address Steelville Mo

19. (a) _____ (b) _____

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3

year 1943 hour 12 noon minute _____ M.

21. I hereby certify that I attended the deceased from 11-28

_____ 1943 to 12-3- 1943

that I last saw her alive on 12-3 1943

and that death occurred on the date and hour stated above.

Immediate cause of death Impingement & Chronic valvular disease of heart

Due to heart

Due to _____

Other conditions 728

(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

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? _____

23. Signature R. G. Parker (M. D. or other)

Address Steelville Mo Date signed 12-4-43

1309

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

RECEIVED

District Health Officer No. 5,

District File Number 14433

Date Filed 1-6-44

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Crawford
(b) City or town Steelville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community Life
years, months or days) (Specify whether

3. (a) PRINT FULL NAME May E. Ritchesson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 2 - 1885
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 2 If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____ (State or foreign country)

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Geo. Schuerch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

5-42104