

FILED FEB 18 1944

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 1231

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Mo.  
(b) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3820<sup>A</sup> ENRIGHT AVE. /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 3 YRS.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17  
(c) City or town ST. LOUIS  
(If outside city or town limits, write "RURAL") 9/19  
(d) Street No. 3820<sup>A</sup> ENRIGHT AVE.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME HATTIE B. RITCHIE

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex FEMALE 5. Color or race Col. 6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years

7. Birth date of deceased. OCTOBER 8 1866  
(Month) (Day) (Year)

8. AGE: Years 77 Months 3 Days 27 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name ALEX HAYES  
13. Birthplace COLUMBIA Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name MARY ADAMS  
15. Birthplace COLUMBIA Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. T. Hayes Sr.  
(b) Address 3820<sup>A</sup> Enright Ave.

17. (a) Centralia Mo. (b) Date thereof Feb. 9, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia Mo. 17

18. (a) Signature of funeral director Boyd Brock  
(b) Address 3704 Finley Av.

19. (a) FEB 8 1944 (b) J. J. Braddock  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 5  
year 1944 hour 9 minute 20 AM

21. I hereby certify that I attended the deceased from 2/2 1944 to 2/5 1944  
that I last saw him alive on 2/5 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration \_\_\_\_\_

Due to Hemorrhage & pneumonia

Due to \_\_\_\_\_  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
' Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 A. R. Parman (M. D. or other)  
Address 3903 Olive Date signed 2/7-44

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.....

*William C. McDowell*..... Registered Apprentice No.....  
working under my personal supervision.

Signed *William C. McDowell*  
Licensed Embalmer No. *2114*

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.**