

Registration District No. 113

Primary Registration District No. 4185

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
 (b) City or town St. Clair
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Highway # 66, N. S. $\frac{1}{2}$ mi. west of # 30
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin 3 1/2
 (c) City or town St. Clair 3
(If outside city or town limits, write "RURAL")
 (d) Street No. On Highway #66 $\frac{1}{2}$ mi. west of # 30
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Bessie Florence Ritchhart

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Alfred O. Ritchhart 6. (c) Age of husband or wife if alive 69 years
 7. Birth date of deceased Dec. 3, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 1 3 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business At home

MOTHER FATHER { 12. Name Marcus Earney
 13. Birthplace Missouri
(City, town, or county) (State or foreign country)
 14. Maiden name Doshia Campbell
 15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred O. Ritchhart (Husband)

(b) Address St. Clair, Missouri

17. (a) Burial (b) Date thereof Jan. 9, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address 6633 Clayton Road, St. Louis, Mo

19. (a) 1-7-1946 (b) E. D. Worthington
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 6
 year 1946 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from Jan. 1, 1946 to 1-6, 1946
 that I last saw h...er... alive on 1-5, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis 4 yrs
 Due to _____
 Due to _____

Other conditions ADDITIONAL SUPPLEMENTARY INFORMATION
(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?
(Specify type of place)
 While at work? _____ (e) Means of injury (1)

23. Signature B. S. Stuhlman (M. D. or other) M.D.
 Address Union, Mo Date signed 1-6-46

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

2
-43
-39
135697

FILED FEB 18 1946

FEB 3 - 1948

RECEIVED

District Health Officer No. 9,

District File Number.....

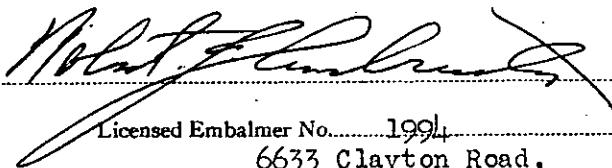
Date Filed 2-14-48

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..... 1994

P. O. Address..... 6633 Clayton Road,
St. Louis (17) Missouri

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. Mar

Registration District No. 11-3

Primary Registration District No. 4185

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town St Clair
(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 _____ years, months or days

3. (a) PRINT FULL NAME Bessie F. Ritchart
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 _____
7. Birth date of deceased Dec 3 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

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

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____ year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____
that I had seen him alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Tuberculosis Pulmonary
Due to _____
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 B. J. Sullivan (M. D. or other) _____
Date signed 2-28-46

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

SUPPLEMENTARY

5183