

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41307

State File No. _____

FILED DEC 22 1951

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 1080

0396

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

1. PLACE OF DEATH a. COUNTY GREENE			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Stone		
b. CITY (If outside corporate limits, write RURAL and give township) Springfield		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Galena, Route 1040		d. STREET ADDRESS (If rural, give location) R#1
d. FULL NAME OF HOSPITAL OR INSTITUTION Springfield Baptist Hospital					
3. NAME OF DECEASED (Type or Print) a. (First) Stella			b. (Middle)	c. (Last) Ritter	4. DATE OF DEATH (Month) (Day) (Year) Dec. 20, 1951.
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar 3, 1892	9. AGE (In years last birthday) 69	10. MONTHS 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY House	11. BIRTHPLACE (State or foreign country) Salem, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Jonathan Mounce		13b. MOTHER'S MAIDEN NAME Angeline Hall	14. NAME OF HUSBAND OR WIFE Charles B. Ritter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles B. Ritter, Galena, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infection of Myocardium due to arteriosclerotic coronary thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Pyelonephritis				INTERVAL BETWEEN ONSET AND DEATH 10 days
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 12, 1951 , to Dec 20, 1951 , that I last saw the deceased alive on Dec 19, 1951 , and that death occurred at 7:40 AM , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Luys Callaway, Jr. M.D.			23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 12/20/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 21, 1951	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) Crane Mo.		
DATE REC'D BY LOCAL REG. 12-20-51	REGISTRAR'S SIGNATURE Will Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Luys H. Maulore Crane Mo			

MAR 19 1957

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.

Signed _____

George H. Manlove

Signed.....
Student Embalmer

Licensed Embalmer No. 3827

P. O. Address Green Ms

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.