

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11529

State File No.

FILED APR 8 1952

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 826

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Carsonville</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u>	
c. LENGTH OF STAY (in this place) <u>3 MONTHS</u>		d. STREET ADDRESS (If rural, give location) <u>3433 Coles Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pean Nursing Home</u>			

3. NAME OF DECEASED (Type or Print) <u>Mamie Ritter</u>			4. DATE OF DEATH <u>Mar. 26, 1952</u>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 3, 1880</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 11 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Patrick Goffney</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Mahoney</u>	14. NAME OF HUSBAND OR WIFE <u>Edward Ritter</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Catherine Reinhardt</u>	ADDRESS <u>Overland, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive & Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>unknown</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Previous Cerebral hemorrhage</u>		4 wks.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>443X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from March 1, 1952, to March 26, 1952, that I last saw the deceased alive on March 25, 1952, and that death occurred at 2:15 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>Lewis Littman MD</u>	(Degree or title)	23b. ADDRESS <u>8231 Clayton Rd (17)</u>	23c. DATE SIGNED <u>3/27/52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Mar. 29, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>3-27-52</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Douke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Ortmann Funeral Home</u>	ADDRESS <u>9222 Lackland</u>
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SW (Licensed Embalmer's Statement on Reverse Side)

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

400
4

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

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.