

THE DIVISION OF HEALTH OF MISSOURI  
 FILED JUL 30 1956 STANDARD CERTIFICATE OF DEATH

24634

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 100

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Sagamore</u>	
b. CITY OR TOWN <u>Louisa</u>		c. CITY OR TOWN <u>Vernon</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		STREET ADDRESS (If rural, give location) <u>812<sup>0</sup></u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Pike Co. Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>BARBARA</u>	c. (Last) <u>RITCHIE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 16 1956</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB. 22 1894</u>	9. AGE (In years last birthday) <u>82</u>	10. If UNDER 1 YEAR Days _____	11. If UNDER 1 HRS. Hours _____	12. If UNDER 15 Mins. Mins. _____
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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	11. BIRTHPLACE (City and State or Foreign Country) <u>Jenison Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>DAMION VITT</u>	13b. MOTHER'S MAIDEN NAME <u>BARBARA VITT</u>	14. NAME OF HUSBAND OR WIFE <u>JAMES FRANK RITCHIE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>E.W. Utt</u>	ADDRESS <u>FRANKFORD, 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
	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>Hypertension</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331X</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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 15, 1956, to July 16, 1956 that I last saw the deceased alive on July 16, 1956 and that death occurred at 3:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>E. P. Hansen</u>	(Degree or title) <u>Dr.</u>	23b. ADDRESS <u>Frankford Mo.</u>	23c. DATE SIGNATURE
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24a. BURIAL, CREMATION, REMOVAL <u>REMOVAL</u>	24b. DATE <u>July 18-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	24d. LOCATION (City, town, or other place) <u>SPRINGFIELD, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 17, 1956</u>	REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Fields &amp; Son</u>	ADDRESS <u>Frankford Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10.48

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 ..... Student Embalmer No. .... working under my personal supervision..

.....  
Signature of Student Embalmer

Signed *Low Fields Meyers*

Licensed Embalmer No. *4093*

P. O. Address *Frankford N.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.