

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003433  
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 148

300  
-57  
33  
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|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY St. Louis                              |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN ST. LOUIS, MISSOURI  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN Ladue 4421<br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION BARNES HOSPITAL  |  | Length of stay in 1b  | d. STREET ADDRESS (If outside, give location)<br>27 Ellsworth Lane<br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>BERTHA M. RITTER  |  |   | 4. DATE OF DEATH<br>Month Day Year<br>JANUARY 5, 1959   |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Aug. 26, 1873   |
| 9. AGE (In years last birthday)<br>85   |  | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br>Illinois  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 13a. FATHER'S NAME<br>Geo. W. Lutes   |   |
| 13b. MOTHER'S MAIDEN NAME<br>Sarah Haynes   |  | 14. NAME OF HUSBAND OR WIFE<br>John H. Ritter, Jr.  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No None   |  | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT<br>Address<br>Mrs. Gladys Hollinshead, 27 Ellsworth Lane<br>Ladue, Mo.  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION<br>DUE TO (b) GENERALIZED ARTERIOSCLEROSIS<br>DUE TO (c) 4201<br>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>CALCIFIC AORTIC STENOSIS |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>1 WEEK<br>YEARS   |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE  |
| 21. I attended the deceased from DEC. 26, 1958 to JAN. 5, 1959 and last saw her alive on JAN. 5, 1959<br>Death occurred at 12:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.  |  |   |   |
| 22a. SIGNATURE<br>C. E. Vermillion, M.D. M. D.  |  | 22b. ADDRESS<br>BARNES HOSPITAL   | 22c. DATE SIGNED<br>1/6/59  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   | 23b. DATE<br>1/7/59  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bellefontaine Cemetery  | 23d. LOCATION (City, town, or country) (State)<br>St. Louis, Mo.  |
| 24. FUNERAL DIRECTOR<br>Louis A. Bopp   |  | ADDRESS<br>Kirkwood   | 25. DATE RECD. BY LOCAL REG.<br>JAN 6 '59   |
| 26. REGISTRAR'S SIGNATURE<br>Paul Smith M.D.<br>MJB.  |  |   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(Licensed Embalmer's Statement on Reverse Side)

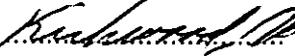
STATEMENT BY LICENSED EMBALMER

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.

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 4512 .....

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