WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. □ AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27631

PLACE OF DEATH

County St Louis

Township ~~Central~~

or

Village

or

City Maplewood (NO. 7591 Mauch St.; Ward)

Registration District No. 786 File No. 31

Primary Registration District No. 4469 Registered No. 31

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Baby Ritchey (Unnamed)

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE ~~MARRIED~~ ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Male	wh	

DATE OF BIRTH Aug (Month) 5 (Day), 1913 (Year)

AGE ___ yrs. ___ mos. ___ ds. If LESS than 1 day, ___ hrs. or 20 min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Infant 0
(b) General nature of industry, business, or establishment in which employed (or employer) — 0

BIRTHPLACE (City or town, State or foreign country) Maplewood

PARENTS
NAME OF FATHER Lee Ritchey
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Fannie Hartzell
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dunkirk Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J A Hartzell

(ADDRESS) 7591 Manchester

Filed 8/6, 1913. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug (Month) 5 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 5, 1913, to Aug 5th, 1913, that I ~~last saw~~ never saw him alive on ~~Aug 5th~~ Aug 5th, 1913, and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Congenital debility failed to reseuscitate

158 (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Premature birth 7th month

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) P M Brossard M. D.

Aug 6th 1913 (Address) Maplewood Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL St Mathews

DATE OF BURIAL Aug. 6, 1913

~~UNDERTAKER~~ J. A. Hartzell Grand father

ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191...., that I last saw h.....alive on....., 191...., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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