96

OCT 24 1929

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

Do not use this space.

31807

1. PLACE OF DEATH
County St Louis
Township Central C.
City St Louis Mo (No. 6734 Schofield Av, St. ..... Ward)
Registration District No. 789
Primary Registration District No. 6033 B
File No. .....
Registered No. 305

2. FULL NAME Alice Ritter
(a) Residence. No. 6734 Schofield Av, St. ..... Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. ~~SINGLE, MARRIED~~, WIDOWED OR ~~DIVORCED~~ (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 1-1866

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
63	8	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Arkansas
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

14. INFORMANT Mrs H. Lingenfelter
(Address) 6734 Schofield Av.

15. FILED 9/30, 1929 Golda Bracy, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 29 1929

17. I HEREBY CERTIFY, That I attended deceased from July 1929, 19..., to Sept 29, 1929, that I last saw her alive on Sept 26, 1929, and that death occurred, on the date stated above, at 10.30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of stomach (primary)
Metastasis in liver -
426
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Angemia -
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Signs & Symptoms

(Signed) Irl G Tremain M. D.
9/29, 1929 (Address) 4448 Shaw Blvd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Matthews Cem.
DATE OF BURIAL: Oct 1 1929

20. UNDERTAKER: E. J. Schmur
ADDRESS: 3125 Lafayette Av.

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.