

No. 2
4-13-40
5-17-39
PI X231

APR 9 1941

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 582

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 23 days
In this community 6 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Phoebe Ellen Ridgeway
3. (b) If veteran, name war C 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Robert R. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Nov. 17 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 3 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Montgomery, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Harvey Ware
13. Birthplace N. Carolina
(City, town, or county) (State or foreign country)
14. Maiden name Permalia Anderson
15. Birthplace Louisiana, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Dunham, daughter
(b) Address 1051 N. Hills Lane, Ferguson

17. (a) BURIAL (b) Date thereof Mar 17-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director J. B. Tanner
(b) Address 6107 Natural Bridge Rd

19. (a) MAR 16 1941 (b) J. R. May
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL")
(d) Street No. 1051 N. Hills Lane,
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 14th
year 1941 hour 12:45 P. M. minute _____ M.

21. I hereby certify that I attended the deceased from 2/21/41
19____, to 3/14/41 19____;
that I last saw her alive on 3/14/41 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure
Due to Toxemia from Infected Gangrenous Ampputation Stump
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy Gangrenous Ampputation Stump

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature John J. Matthews (M. D. or other) _____
Address St. Louis County Hosp. Date signed 3/15/41

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

16
2
3

MOTHER FATHER

96
1
6
2

Duration
1 day

6 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

74C

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11948

Registrar's No. 587

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH

(a) County St. Louis Clayton
(b) City or town St. L.
(c) Name of hospital or institution:
St. L. Co.
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) If foreign born, how long in U. S. A.?..... years.

3. (a) PRINT FULL NAME

Phoebe E. Ridgeway

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced.....

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: 76 Years Months Days If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) 376-v (b) Phoebe E. Ridgeway (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 4-41 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....

that I last saw him..... alive on..... and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to... amputated gangrene -

arteriosclerosis

Other conditions.....

(Include pregnancy within 3 months of death) 99

Major findings: Of operations.....

Of autopsy Gang. Amp. Stumps

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature John S. Mathews (M. D. or other).....

Address Co. St. Louis Date signed.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

