

S. No. 2  
 OM-5-43  
 v. 5-17-39  
 I X36671

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **21863**  
 Registrar's No. **53**

FILED JUL 9 1947  
 Registration District No. **278**

Primary Registration District No. **3054**

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

1. PLACE OF DEATH:

(a) County **Pike County**  
 (b) City or town **Louisiana, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **Pike County Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **8 hrs. & 25 min.**  
(Specify whether)

In this community **same**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Pike**  
 (c) City or town **Louisiana**  
(If outside city or town limits, write "RURAL")  
 (d) Street No. **1**  
(If rural, give location)  
 (e) Citizen of foreign country? **0**  
(Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Patricia Ann Kritz**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced **Infant**  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **2 26 1947**  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day **8 hrs. 25 min.**  
min.

9. Birthplace **Pike County Hospital - Louisiana, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **New Born**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Gerald Kritz**  
 13. Birthplace **Calhoun Co, Mo**  
(City, town, or county) (State or foreign country)  
 14. Maiden name **Dorothy Marie Ingram**  
 15. Birthplace **Pike Co, Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Gerald Kritz**  
 (b) Address **Raymond**

17. (a) **Burial** (b) Date thereof **May 28 - 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Eolia Cemetery**

18. (a) Signature of funeral director **R E Gooch**  
 (b) Address **Eolia Mo**

19. (a) **May 28 - 1947** (b) **R E Gooch Deputy**  
(Date received local registrar) (Registrar's signature)  
**June 3/47 Bernice Collier**  
(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** Day **27**, Year **1947**  
 hour **4:50 P.M.** M. **PM**

I hereby certify that I attended the deceased from **birth at 2:30 PM, May 26, 1947** to **May 27, 1947**  
 and that death occurred on the date and hour stated above.

that I last saw her alive on **May 27, 1947**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Intracranial Hemorrhage.**  
 Due to **Cerebral Contusion sustained in Utero before birth when mother sustained a fall 2 days prior to childbirth.**

Other conditions **Intrauterine Pressure with bloody Spinal Fluid.**  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy **160 P**

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

(a) Accident, suicide, or homicide (specify) **Accident**  
 (b) Date of occurrence **5-24-47**  
 (c) Where did injury occur? **on city sidewalk per #21**  
(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)  
 Means of injury \_\_\_\_\_

23. Signature **Robert L. Lindrae M.D.**  
 Address **216 Georgia St. Louisiana, Mo.** Date signed **5/27/47**

Duration **1 day**

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 10  
District File Number 2-47-843  
Date Filed JUL - 7 1947

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 Norman E. Goch

Licensed Embalmer No. 2342

P. O. Address Eolia, Mo

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.