

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21032**

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. **5242**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis 0) c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 17	
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital		d. STREET ADDRESS (If rural, give location) 4225W Farlin Ave. 0	

3. NAME OF DECEASED (Type or Print) a. (First) Katherine	b. (Middle) D. K.	c. (Last) Forbes	4. DATE OF DEATH (Month) (Day) (Year) July 1, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 15, 1865	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (State or foreign country) Fort Madison, Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Peter Mausehund	13b. MOTHER'S MAIDEN NAME Unknown Schaumleffel	14. NAME OF HUSBAND OR WIFE Robert Forbes
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Wm. R. Moenster, 4225W Farlin	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gangrene right leg + thigh		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Subacute right femoral artery DUE TO (c) leukemia		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		-	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 99
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HSAH
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22. I hereby certify that I attended the deceased from **3-16**, 19**49** to **7-1**, 19**49**, that I last saw the deceased alive on **7-1**, 19**49**, and that death occurred at **12:05 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Francois R. Ritchie M.D.	23b. ADDRESS 5233 Ardmore Ave.	23c. DATE SIGNED 7-2-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/5/49	24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL JUL 3 1949	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE PROVOST UND. CO., 3710 N. Grand	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. James Ritchie
5233 Waterman

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.

Signed Albert Mayfield

Signed.....
Student Embalmer

Licensed Embalmer No. 3077

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.