No. 300
10.48

FILED SEP 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28474

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 100 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 2½ mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Johns Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY: 99
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vandalia
d. STREET ADDRESS (If rural, give location): RR = 225 N 7th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Lola
b. (Middle):
c. (Last): Ritter

4. DATE OF DEATH (Month) (Day) (Year): 8 - 26 1949

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 12-12-1872 ~~8-26-49~~
9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Vandalia Ill
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Sharp
13b. MOTHER'S MAIDEN NAME: Elizabeth Andrews
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: H Bolt MD
ADDRESS:

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 17 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

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 ☒ NO ☐

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): 49 C
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 162X

22. *I hereby certify that I attended the deceased from* Aug 7 *1949, to* Aug 26 *1949, that I last saw the deceased alive on* Aug 26 *1949, and that death occurred at* 6:15 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas H. Bolt M.D.
23b. ADDRESS: St. Johns Hosp.
23c. DATE SIGNED: 8/28/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8-27-1949
24c. NAME OF CEMETERY OR CREMATORY: South Hill
24d. LOCATION (City, town, or county) (State): Vandalia Ill

DATE REC'D BY LOCAL REGISTRAR: AUG 2
REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Rowland Mortuary Service Inc. 4104 Manchester Ave. St. Louis 10, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Student .....
Student Embalmer

Signed Van M Sizemore

Licensed Embalmer No. 4343

P. O. Address St Louis 10 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.