

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 42817  
Registrar's No. 10575

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. 42817		Registrar's No. 10575			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST. LOUIS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>12 4571 Kensington</b>		2129 0					
3. NAME OF DECEASED (Type or Print) <b>EMMA</b>			a. (First)		b. (Middle)		c. (Last) <b>SIMON</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>NOVEMBER 9, 1954</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>JULY 27, 1872</b>		9. AGE (In years last birthday) <b>82</b>		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) <b>AT HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS</b>			12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <b>GEORGE RITCHIE</b>				13b. MOTHER'S MAIDEN NAME <b>HELEN YOUNG</b>				14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>HOSPITAL RECORD</b>			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) <b>Acute Ulcerative Cystitis</b>  ANTECEDENT CAUSES - Possible Sepsicemia - Possible Carcinoma of Urinary Bladder  DUE TO (b) _____  DUE TO (c) <b>Syphilis.</b>						INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) _____		029 X				
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? _____						
22. I hereby certify that I attended the deceased from <b>10-26-54</b> , 19____, to <b>11-9-54</b> , 19____, that I last saw the deceased alive on <b>11-9-54</b> , 19____, and that death occurred at <b>8:00A</b> m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <b>Samuel A. Joseph M.D.</b>					23b. ADDRESS <b>1515 Lafayette Avenue</b>			23c. DATE SIGNED <b>11-10-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>11/22/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>WALTON</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, County Mo.</b>					
DATE RECD BY LOCAL REG. <b>NOV 20 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. Mullen 5165 Helms Bl.</b>						

(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 *No Embalming*....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert J. Muller*.....  
*Lawrence Muller & Sons Inc.*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.