

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038156  
State File No. \_\_\_\_\_

FILED NOV 3 1958

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9935

|  |                              |  |  |   |  |   |
|--|------------------------------|--|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                              |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Illinois</u> b. COUNTY <u>ST. CLAIR</u>  |   |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><u>St. Louis</u>   |                              | c. LENGTH OF STAY (In this place)<br><u>2 DAYS</u>   | c. CITY OR TOWN<br><u>CASEVILLE</u>  |   | d. Is Residence within limits of a city or incorporated town?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Firmir Deaslodge Hospital</u>  |                              |  | e. STREET ADDRESS (If rural, give location)<br><u>32 19 LONDOKERRY DRIVE</u>   |   |  |   |
| 3. NAME OF DECEASED<br>a. (First) <u>Betty</u> b. (Middle) <u>JANE</u> c. (Last) <u>RITSON</u>   |                              |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Oct 19 58</u>  |   |  |   |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>MARRIED</u>                               | 8. DATE OF BIRTH<br><u>APRIL 24, 1925</u>  |   | 9. AGE (In years last birthday) <u>33</u><br># UNDER 1 YEAR Months Days # UNDER 1 HRS. Hours Min.                                    |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>_____   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>JAN ANTONIO, TEXAS</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13a. FATHER'S NAME<br><u>CRAMER LOVELADY</u>   |                              | 13b. MOTHER'S MAIDEN NAME<br><u>IRENE SMALL</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>ARTHUR RITSON</u>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>46428-0612</u>   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Clathur Ritson 19 Londokerry Dr.</u>   |   |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |                              |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CARDIAC ARREST</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>SUB AORTIC STENOSIS</u><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>754.5</u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Congenital</u> |
| 19a. DATE OF OPERATION<br><u>9/29/58</u>   |                              | 19b. MAJOR FINDINGS OF OPERATION<br><u>Sub Aortic Stenosis</u>   |  |   | 20. AUTOPSY? /<br>YES <input checked="" type="checkbox"/> NO <input 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)   |  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                              | 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 <u>10-17</u> , 19 <u>58</u> , to <u>10-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-19</u> , 19 <u>58</u> , and that death occurred at <u>5:00 AM.</u> , from the causes and on the date stated above. |                              |  |  |   |  |   |
| 23a. SIGNATURE<br><u>Charles A. Nigh</u>   |                              |  | 23b. ADDRESS<br><u>M.O. 1335 S. Grand</u>  |   | 23c. DATE SIGNED<br><u>10-19-58</u>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                              | 24b. DATE<br><u>Oct. 22, 1958</u>  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>MT. CARMEL</u>  |   | 24d. LOCATION (City, town, or county) (State)<br><u>BELLEVILLE ILL.</u>  |   |
| DATE REC'D BY LOCAL REG.<br><u>OCT 20 1958</u>   |                              | REGISTRAR'S SIGNATURE<br><u>Earl Smith M.D.</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>Miss Sarah Barnes 1416 St. Louis Ave. E. St. Louis, Ill.</u> |  |   |

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

(Licensed Embalmer's Statement on Reverse Side)

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 not embalmed, Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed John Maher

Licensed Embalmer No. 8294

P. O. Address E. St. Louis,

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.