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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH

County St. Louis Registration District No. Decourse Hospital File No. 6070
Township Washington Primary Registration District No. 15 Registered No. 6070
City St. Louis (Word)

2. FULL NAME

Sarah J. Ryan
(a) Residence No. 4534 Washington St Ward. 15 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? 3 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov-11-1891
7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min. 29 7 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salisbury
(b) General nature of industry, business, or establishment in which employed (or employer) Candy Dept Bush Bee
(c) Name of employer Dr. Sota

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) De Sota Mo

10. NAME OF FATHER Samuel L. Ryan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Louise S. Hurst

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) La Crosse Wisconsin

14. INFORMANT Frank E. Ryan
(Address) 3125 Washington St

15. FILED May 6 1920
REGISTRAR Max C. Starnesoff

5. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 30 1920
17. I HEREBY CERTIFY, That I attended deceased from June 17, 1920, to June 30, 1920 that I last saw her alive on June 30, 1920, and that death occurred, on the date stated above, at about 6:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion of following acute intestinal obstructions with fecal vomiting
Fibroid tumor of uterus
CONTRIBUTORY acute renal insufficiency (SECONDARY) a few days (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 18
IF NOT AT PLACE OF DEATH.

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? usual signs & labors
(Signed) Dr. A. A. Swannick M.D.
, 19 (Address) Warren Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL De Sota Mo DATE OF BURIAL July 2 1920

20. UNDERTAKER B. L. Hurst ADDRESS 4821 Easton

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 8 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County.....*St. Louis*..... Registration District No. *791*..... File No. *6910*
 Township.....*St. Louis*..... Primary Registration District No. *1002*..... Registered No. *6910*
 City.....*St. Louis*..... (N. *St. Louis*) *Meeworth Hospital* St. Ward)

2. FULL NAME

(a) Residence. No. *4534 Washington*..... Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* | 4. COLOR OR RACE *W.* | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *D*
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov-11-1891*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
29 | *7* | *23*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Saleslady*
 (b) General nature of industry, business, or establishment in which employed (or employee) *Candy store (Candy store)*
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis Mo*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Samuel E. Ryan*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *St. Louis Mo*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Louise D. Hunt*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis Mo*
 (STATE OR COUNTRY)

14. INFORMANT *Frank E. Ryan*
 (Address) *St. Louis*

15. FILED *Max Starnoff*
 19 *20* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 30 19 20*

17. I HEREBY CERTIFY That I attended deceased from *June 18th 1920* to *June 30 1920*, and that I last saw the deceased alive on *June 30 1920*, and that death occurred on the date stated above, at *6:45 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
with renal insufficiency

I do not know exact length of time (duration) of disease.

CONTRIBUTORY (SECONDARY) *Generalized Intestinal Obstruction with fecal vomiting*

18. WHERE WAS DISEASE CONTRACTED *and vomiting ceased on June 24th 1920. Bowels moved freely 24th of June. Deceased normal in abdomen. Flatulent*

IF NOT AT PLACE OF DEATH: DATE OF.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS? *usual clinical signs and presence of albumin & casts in*
 (Signed) *Dr. A. Edward Mersbach* M. D.
 , 19 (Address) *Marina Bldg.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. Louis Mo* DATE OF BURIAL *July 2 19 20*

20. UNDERTAKER *O. L. Gurtey* ADDRESS *421 Easton*

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association.]

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