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

Do not use this space.

25874

1. PLACE OF DEATH

County..... Registration District No. 791

Township..... Primary Registration District No. 1003

City..... (No. Westminster Hosp St. ..... Ward)

File No. ..... Registered No. 7485

2. FULL NAME Margaret L Ryan

(a) Residence. No. 4201 W 11 Str St., 9 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Patrick S. Ryan

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 8-23-1878

7. AGE: Years 48 | Months 11 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Bernard Feuerstein

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

12. MAIDEN NAME OF MOTHER: Victoria Boeschert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Patrick S. Ryan
(Address) 4201 W 11 Str

15. FILED AUG 27 1927 19..... Max C Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Aug 19, 1927, that I last saw her alive on Aug 19, 1927, and that death occurred, on the date stated above, at 6 20 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Anemia Coma

130

128

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (SECONDARY): Acute Nephritis

Non Puerperal from a cold (duration) ..... yrs. ..... mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed) Wm A. Knight, M.D.

8/19, 1927 (Address) 8612 Halls Ferry Rd

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Charles Mo

DATE OF BURIAL: Aug 22 1927

20. UNDERTAKER: H. A. Stock Und Co

ADDRESS: 2117 E. Grand

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.