

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.

REC'D APR 12 1939

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

791
1003

8374
Do not use this space.

1. PLACE OF DEATH
 (a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No..... **2139**
 or **St. Louis Mo.**
 (c) City..... (d) Street No. **5600 Arsenal St.** St.
34 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred **34** yrs. **9** mos. **12** ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Marie Ryan.**
 (a) Residence, No. **2020 Nolan - County.** St. **NR** **Vinita Park**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 **Joseph Ryan.**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **May 20th 1904**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 9 12

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. **Housewife.**
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Missouri.**

FATHER
 13. NAME **Unknown**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER
 15. MAIDEN NAME **Marie Hartwig.**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

17. INFORMANT (ADDRESS) **Stella Grady. 5600 Arsenal St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE. **Calvary Cemetery** DATE **March 7 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **F. Mullen Bros 4259 Lindell Blvd.**

20. FINGERPRINTS **J. B. Buecher Local Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 4th 1939**

22. I HEREBY CERTIFY, That I attended deceased from **2/18 1939** to **3/4 1939**
 I last saw her alive on **3/4 1939** Death is said to have occurred on the date stated above, at **8:50 A.M.**
 The principal cause of death and related causes of importance were as follows:
Diphtheria, Funicular
 Other contributory causes of importance **Myocarditis, Diphtheritic**

Name of operation..... Date of.....
 What test confirmed diagnosis? **Cult.** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) **Geo. S. Buecher M. D.**
 (Address) **Isolation Hosp.**

MAR 6 1939

(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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *Howard P. Rowland*
Licensed Embalmer No. *3114*
P. O. Address *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 this body is not embalmed, above space should be left blank.