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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30695

Registration District No. 19 OCT 25 1940

Primary Registration District No.

Registrar's No. 7972

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST. ANTHONY HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 DAYS (Specify whether years, months or days)

In this community 65 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County

(c) City or town ST. LOUIS 25
(If outside city or town limits, write "RURAL")

(d) Street No. LENOX HOTEL
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 65 YEARS years.

3. (a) PRINT FULL NAME HELENA RYAN

3. (b) If veteran, name war

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife WILLIAM RYAN

6. (c) Age of husband or wife if alive years

7. Birth date of deceased AUG. 7 1861 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day hr. min.
79	1	16	

9. Birthplace IRELAND
(City, town, or county) (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

MOTHER FATHER

12. Name JOHN WOODS

13. Birthplace IRELAND
(City, town, or county) (State or foreign country)

14. Maiden name ELIZABETH DOUGHERTY

15. Birthplace IRELAND
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. WILLIAM F. VICTOR

(b) Address LENOX HOTEL

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 26, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) SEP 25 1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 23, year 1940 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia, Myocarditis, Chronic; Fractured Femur; suffered when deceased fell

Due to at her daughter's home at 624 No. 38th St., East St. Louis, Illinois, on Sept.

Due to 17th, 1940, exact time unknown.

Duration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Sept. 17, 1940

(c) Where did injury occur? East St. Louis, Ill. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Home (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

(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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.