

FILED JUN 25 1941

STANDARD CERTIFICATE OF DEATH

State File No. 17019

791

1003

Registration District No.

Primary Registration District No.

Registrar's No. 4537

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: Josephine Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") L717  
(d) Street No. 3231 Eads Ave  
(If rural, give location) 9  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William T. Ryan

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased October 18 1924  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
16 7 11 hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business Hadley School

12. Name Edward J. Ryan

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

14. Maiden name Elizabeth Grace

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

16. (a) Informant Edward J. Ryan  
(b) Address 3231 Eads Ave.

17. (a) Burial (b) Date thereof 5/31/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director E. J. Schnur  
(b) Address E. J. Schnur 3225 Lafayette

19. (a) MAY 30 1941 (b) T. Budrek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 29  
year 1941 hour 2:35 minute A M.

21. I hereby certify that I attended the deceased from May 27 1941 to May 29 1941  
that I last saw ~~him~~ her alive on 5/28 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Acute Peritonitis

Due to \_\_\_\_\_

Ruptured Appendix

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Ruptured Appendix  
Of operations General Peritonitis  
Of autopsy no  
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) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_

23. Signature Albert Hoover (M. D. or other) 0  
Address 370 2 Eads Date signed \_\_\_\_\_

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

MOTHER FATHER

---

---

**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 Joe Ballmer  
Licensed Embalmer No. 48014  
P. O. Address 3125 Lejaytown

**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, fact should be so stated above.**