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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 17 1942

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 4884

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 1084

**1. PLACE OF DEATH:**

(a) County None

(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. John's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Weeks - 3 days (Specify whether

In this community 30 Years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County None

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 6910 West Park Avenue. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country X X X X X

3. (a) PRINT FULL NAME Margaret A. Ryan

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Thomas A. Ryan

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased February (Month) 19 (Day) 1879 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 11 | 25 | 10 hr. 55 min. |

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

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name James E McKeown
13. Birthplace Ireland (City, town, or county) X X X (State or foreign country)

MOTHER
14. Maiden name Mary Kerr
15. Birthplace X X X (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Thos A Ryan

(b) Address 6910 West Park

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 6 /1942 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Watson-Bocklage Fun Home

(b) Address 6536 Clayton Road

19. (a) FEB 4 1942 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 3rd 1942 year 1942 hour 10 minute 55 M.

21. I hereby certify that I attended the deceased from Jan 1- 1938, 1938, to Feb 3rd, 1942 that I last saw her alive on Feb 3rd, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis also Cerebral Hemorrhage

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. A. O'Connor (M. D. or other)

Address 1316 A n Grand Date signed Feb 6-1942

(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.....

Licensed Embalmer No.....1861.....

P. O. Address.....

**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.**