

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

6335

FILED JUL 24 1943 18

Registration District No.

1003

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

1. PLACE OF DEATH:

(a) County St. Louis
 (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. Louis City Sanitarium 2
(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")
 (d) Street No. 6411 Potomac St.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Julia Ryan

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

4. Sex Female 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 July 22 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>11</u>	<u>19</u>	_____ hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

MOTHER FATHER { 12. Name Matthew Ryan
 13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
 14. Maiden name Annie Davey
 15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robert Updike
 (b) Address 6411 Potomac St.

17. (a) Burial (b) Date thereof 7-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Cullinane Bros.

(b) Address 1710 N. Grand Blvd.

19. (a) III 7 0 (b) J. J. Brueck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
 year 1943 hour 2 minute 35 PM

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

Immediate cause of death Fracture left femur
without splint, suffered when
deceased fell in home kitchen
sanitarium in ward 20-1 at city
sanitarium June 24 1943
 Due to fracture

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 000
 (b) Date of occurrence June 24 1943
 (c) Where did injury occur? at home
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place

While at work? _____ (Specify type of place) _____
 Means of injury fall

23. Signature Alfred P. Jones (M. D. or other) _____

Address Supply Street Date signed 7/13/43

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 Fred Frick

Licensed Embalmer No. 3186

P. O. Address St. Louis, Mo.

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.