

1994

V. S. No. 2
100M-2-43
Re. 5-17-39
I X3589

27031

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 761A

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days (Specify whether _____)

In this community Life years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME Robert Ryan

3. (b) If veteran, name war Unknown

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased May 1, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68	1	12	_____ hr. _____ min.
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9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation O. A. -- Old Age Assistance

11. Industry or business O. A. A.

MOTHER FATHER { 12. Name George Ryan

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

14. Maiden name Louise Manning

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

16. (a) Informant Ann P. Morrison

(b) Address St. Louis City Hospital.

17. (a) _____ (b) Date thereof 8-36-43
(Burial, reinterment, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital

19. (a) AUG 25 1943 (b) J. F. Budeck
(Date received local registrar's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

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

(d) Street No. 3225 Montgomery St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13, year 1943 hour 5:05 minute P. M.

21. I hereby certify that I attended the deceased from August 9, 1943 to August 13, 1943 that I last saw him alive on August 13, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage from the pharynx

Due to Erosion of internal carotid artery into pharynx

Due to Carcinoma of Pharynx

Major findings: Of operations _____

Of autopsy Erosion of int. carotid artery

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) (a) Means of injury _____

23. Signature Geo. W. Salvan (M. D. or other) _____

Address 1515 Lafayette Avenue. Date signed 8/14/43

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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.....

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.