

Registration District No. **3 1944** Primary Registration District No. **6076**

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

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **Lemay**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mt. St. Rose Sanitarium
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 yr.**
 In this community **life 24 Years**
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **City of St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5218 Murdock**
 (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Eileen Ryan**
 3. (b) If veteran, name war **None** 3. (c) Social Security No. _____

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 **April 3, 1920**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	24	1	22	hr. _____ min. _____

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

10. Usual occupation **stenographer**
 11. Industry or business **Phelan Faust Paint Co.**

12. Name **Thomas Ryan**
 13. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Nora O'Reilly**
 15. Birthplace **Unknown Ireland**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Thomas Ryan**
 (b) Address **5218 Murdock**
 17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **5-29-44**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **SS Peter and Paul Cemetery**

18. (a) Signature of funeral director **Southern Funeral Home**
6322 South Grand Blvd.
 (b) Address
 19. (a) **MAY 29 1944** (Date received local registrar) (b) **E. G. McHarran, M.D.** (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **May** day **25th**
 year **1944** hour **10:00** minute _____ a. M.
 21. I hereby certify that I attended the deceased from **1/13/43**
 _____, 19____ to **5/25**, 19**44**
 that I last saw h. **ev.** alive on **5/24**, 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Pulmonary tuberculosis 18 mo.
 Due to _____
 Due to _____
 Other conditions **Tuberculosis enteritis 3 mo.**
 (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations **135-1**
 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) _____
 (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) (e) Means of injury _____
 23. Signature **[Signature]** (M. D. or other) _____
 Address **462 1/2 Del Taylor** Date signed **5-2**

Mr. John Devine
462 North Taylor

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..... *Virgil L. Berryman*
Licensed Embalmer No. *4018*
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.