

6018
S. No. 2
OM-2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

22510

FILED AUG 3 1945 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

6427

1. PLACE OF DEATH:

(a) County St. Louis, Mo.
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 21 days
(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. 112 South 4th St.
(If rural, give location) 9 25
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM RYAN

3. (b) If veteran, name war UNK. 3. (c) Social Security No. UNK.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife UNKNOWN 6. (c) Age of husband or wife if alive 1878 years

7. Birth date of deceased NOV 21 1878
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace UNK MISSISSIPPI
(City, town, or county) (State or foreign country)

10. Usual occupation UNK

11. Industry or business

12. Name JACK RYAN

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

14. Maiden name SALLIE ANDERSON

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

16. (a) Informant T. M. RYAN

(b) Address CHARLES DALE, MISS.

17. (a) REMOVAL (b) Date thereof 7-24-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GRENADA, MISS.

18. (a) Signature of funeral director ALBERT H. HOPPE

(b) Address 4700 WASHINGTON

19. (a) JUL 24 1945 (b) J. A. Buesch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1945 hour 2:48 minute A M.

21. I hereby certify that I attended the deceased from July 3, 1945, to July 24, 1945 19. ;
that I last saw him alive on July 24, 1945 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Duration _____

Cerebral Hemorrhage

Due to _____

Due to _____

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) _____

(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 injury) _____
(c) Means of injury _____

23. Signature James J. Stout (M. D. or other) _____

Address 155 Lafayette Avenue Date signed 7/24/45

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

Albert G. Kappeler

Licensed Embalmer No: 2171

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.