

**FILED JUN 20 1946**  
Registration District No. **318**

Primary Registration District No. **1003**

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: Luthern Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3-days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 600  
(c) City or town St. Louis 577  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5439 Cabanne Ave.  
(If rural, give location) 10  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country:

3. (a) PRINT FULL NAME

Lillian M. Ryan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced W.  
6. (b) Name of husband or wife Dennis A. Ryan 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased June 27th., 1873  
(Month) (Day) (Year)

8. AGE: Years 73 Months 11 Days 11 If less than one day br. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name Frank Taylor  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Virginia Bishop  
15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Virginia E. Ryan

(b) Address 5439 Cabanne Ave.

17. (a) Burial (b) Date thereof 6-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Donnelly  
(b) Address 3840 Lindell Blvd.

19. (a) JUN 10 1946 (b) J. J. Bussard  
(Date received local health officer) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th.,  
year 1946 hour 10 minute 15 a.m.

21. I hereby certify that I attended the deceased from 6/3 to 6/8  
that I last saw him alive on 6/8 and that death occurred on the date and hour stated above.

Immediate cause of death

Pulmonary embolism

Due to Aspiration for postmortem

Other conditions Intestinal Obstruction from  
(Include pregnancy within 3 months of death)

Major findings: Adhesions

Of operations: Adhesions  
Of autopsy: \_\_\_\_\_

Duration  
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 work) (Means of injury)

23. Signature Ortho G. Hansen MD  
(M. D. or other) 6/10/46

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

Embalmer  
3012 Lafayette 10:50-12:00

**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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lindell

**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.**