

S. No. 2
M-5-43
5-17-39
I X36671

FILED **SEP 21 1946**
Registration District No. **318**

Primary Registration District No. **1003**

State File No. _____
Registrar's No. **8718**

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:
I436 North 24th. St.
(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

3. (a) PRINT FULL NAME Jeremiah Joseph Ryan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male White 5. Color or race

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

6. (b) Name of husband or wife Catherine Ryan

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Feb. 22nd. 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>75</u>	<u>7</u>	<u>17</u>	hr. _____ min.

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

10. Usual occupation Salesman

11. Industry or business _____

MOTHER FATHER { 12. Name Ryan

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

14. Maiden name Unknown

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

16. (a) Informant Catherine Ryan

(b) Address I436 North 24th. St.

17. (a) Burial (b) Date thereof 10/12/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Funeral Dir

(b) Address 2849 North Euclid Ave.

19. (a) OCT 10 1946 (b) J. F. Bruesch
(Date received local registrar) (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. I436 North 24th. St.
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9th.
year 1946 hour 3.00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 1920
to Oct 9, 1946
that I last saw him alive on Oct 9, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke coma 4 days

Due to Stroke

Due to HT

Other conditions Hypertension, Aneurysm
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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? _____

23. Signature AM Kroll (M. D. or other) J

Address 2416 2nd Grand Date signed 10/10/46

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

Dr. A.M. Krall

2416 North Grand Ave.

FR. 4270

OCT 10 1946

Embalmer separate cert to be filed

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.