

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25243  
6053  
Registrar's No.

318

1003

BIRTH NO. REG. DIST. NO. PRIMARY REG. DIST. NO.

1. PLACE OF DEATH  
a. COUNTY St. Louis  
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  
c. LENGTH OF STAY (In this place) 1  
d. FULL NAME OF HOSPITAL OR INSTITUTION 5928A Wells

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE MO b. COUNTY MO  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis  
d. STREET ADDRESS (If rural, give location) 5928A Wells

3. NAME OF DECEASED (First) Catherine (Middle) Ryan (Last) Ryan  
4. DATE OF DEATH (Month) (Day) (Year) 7-9-49

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH MAY 27 1875 PLACE (In years and birth day) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY Over Home 11. BIRTHPLACE (State or foreign country) ST LOUIS MO 12. CITIZEN OF WHAT COUNTRY? U. S. A

13a. FATHER'S NAME JOHN DOYLE 13b. MOTHER'S MAIDEN NAME ELISBETH BYRON 14. NAME OF HUSBAND OR WIFE DENNIS J RYAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NO RE. 17. INFORMANT'S SIGNATURE OR NAME Thos B Ryan ADDRESS 5428 Wells

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
\*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Apoplexy  
ANTECEDENT CAUSES Cardio-renal Vasculor DUE TO (b) Arteriosclerosis  
Chronic Myocarditis DUE TO (c) Arteriosclerosis  
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 930 (STATE) MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? H222

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_, from the causes and on the date stated above.

23a. SIGNATURE W P Hamilton M.D. (Degree or title) 23b. ADDRESS 8363 Hall's Ferry 23c. DATE SIGNED July 9 49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24b. DATE 7-12-49 24c. NAME OF CEMETERY OR CREMATORY CALVARY 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE J B Fabaler 25. FUNERAL DIRECTOR'S SIGNATURE Walt Walsh Barnes ADDRESS 1416 St. Louis Ave. East St. Louis, Ill.

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

NOV 9 7 1919

**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 \_\_\_\_\_

*Not embalmed.*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Phillip Ogden*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

*7091*

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.