

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1743

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN JEFF. BRKS. MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VET. ADMIN. HOSPITAL.		d. STREET ADDRESS (If rural, give location) 2603 N. 20th Street	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle) J.	
		c. (Last) RYAN	
4. DATE OF DEATH (Month) (Day) (Year) July 19, 1950			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 10-6-88
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days IF UNDER 21 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) kitchen helper		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME PHILIP RYAN		13b. MOTHER'S MAIDEN NAME MARGARET JONES	
14. NAME OF HUSBAND OR WIFE BERTHA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT'S SIGNATURE OR NAME V.A. HOSPITAL RECORDS, JEFF. BRKS. MO.		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CIRRHOSIS OF LIVER		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES			
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
DUE TO (b) HYPERTENSIVE CARDIO VASCULAR DISEASE			
DUE TO (c) _____			
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? 443x	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443x	
22. I hereby certify that I attended the deceased from 6-19 , 19 50 , to 7-19 , 19 50 , and that death occurred at 4:10A m., from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) CHIEF, ADMITTING SERVICE		23b. ADDRESS V.A. HOSPITAL, JEFF. BRKS. MO.	
23c. DATE SIGNED 7-19-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-21-50	24c. NAME OF CEMETERY OR CREMATORY NATIONAL	24d. LOCATION (City, town, or county) (State) JEFF. BRKS, MO.
DATE REC'D BY LOCAL REG. 7-19-50	REGISTRAR'S SIGNATURE Herbert R. Sombky, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. SCHNUR, 3125 Lafayette, St. Louis, Mo.	

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

4000

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.