

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHDate Filed No. 14674  
3260

FILED APR 20 1951

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BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Delaware		b. COUNTY New Castle	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Wilmington		8070	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1209 Hamilton		d. STREET ADDRESS 218 West 17th		8	
3. NAME OF DECEASED (Type or Print) Charles		a. (First) Ryan		b. (Middle)	
c. (Last)		4. DATE OF DEATH April 4, 1951		(Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Nov. 9, 1879	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Du Pont Co.		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
13a. FATHER'S NAME John T. Ryan		13b. MOTHER'S MAIDEN NAME Elizabeth Ryan		14. NAME OF HUSBAND OR WIFE Unavailable	
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME Helen M. Murphy, 1209 Hamilton	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocarditis (2) (b) Acute virus pneumonia (1) (c) Coronary insufficiency (3) II. OTHER SIGNIFICANT CONDITIONS Chor. hepatitis Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH Years 2 1 week 2 yrs Years
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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) (STATE)	
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? H201	
22. I hereby certify that I attended the deceased from 8-5, 1944, to April 4, 1951, that I last saw the deceased alive on 4-2, 1951, and that death occurred at 9:00 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Wm. J. Sheahan		23b. ADDRESS 2322 Kingshighway		23c. DATE SIGNED 4/5/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-7-51		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Harrigan-Sheahan, 4700 Washington Bldg			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 6 1951		25. FUNERAL DIRECTOR'S SIGNATURE Harrigan-Sheahan, 4700 Washington Bldg			

(Licensed Embalmer's Statement on Reverse Side)

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

**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.....

*J. W. D. Ambler*  
Licensed Embalmer No. .... 365-  
P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.