

No. 300
10-48

NOV 14 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37299

BIRTH NO. 81311 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2768

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay 23	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt 8 Box 846 Lemay Mo.		d. STREET ADDRESS (If rural, give location) Rt 8 Box 846	

3. NAME OF DECEASED (Type or Print)	a. (First) Dennis	b. (Middle) Micheal	c. (Last) Ryan	4. DATE OF DEATH (Month) (Day) (Year) Oct. 26 1952
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child	8. DATE OF BIRTH Oct. 6th 1952	9. AGE (In years last birthday) no	# UNDER 1 YEAR 0	Days 20	# UNDER 12 HRS. 0	Hours 0	Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ***NOTE***	10b. KIND OF BUSINESS OR INDUSTRY ***NOTE***	11. BIRTHPLACE (State or foreign country) St Louis Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Everett Ryan	13b. MOTHER'S MAIDEN NAME Lorraine	14. NAME OF HUSBAND OR WIFE ***NOTE***
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -NO-	16. SOCIAL SECURITY NO. -NONE-	17. INFORMANT'S SIGNATURE OR NAME Mr. Everett Ryan	ADDRESS Rt 8 - Box 846 Lemay Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital malformation of Heart		INTERVAL BETWEEN ONSET AND DEATH 20 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 7544		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prematurity		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **OCT 6, 1942**, to **OCT 26, 1952**, that I last saw the deceased alive on **OCT 24, 1952**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE J. Schumdey (Degree or title) MD	23b. ADDRESS 2026 59th St Louis Mo	23c. DATE SIGNED 10/27/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct 27th 1952	24c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cem.	24d. LOCATION (City, town, or county) (State) St Louis Mo
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DATE REC'D BY LOCAL REG. 10-27-52	REGISTRAR'S SIGNATURE Hubert R. Domb-M.D.	FUNERAL DIRECTOR'S SIGNATURE Foy Funeral Home	ADDRESS 4100 Lemay Ferry Rd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1000

EMBS 307

DEPT. OF HEALTH

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 **This body was not Embalmed**
J. Paul Taylor

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.