

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37554

State File No. \_\_\_\_\_

FILED OCT 27 1953

318

Registrar's No. 9010

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. 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) 2 WKS	c. CITY OR TOWN Maplewood		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Johns Hospital			e. STREET ADDRESS (If rural, give location) 7428 Zepher		
3. NAME OF DECEASED a. (First) Pearl (Type or Print)			b. (Middle) Ryan		c. (Last) Ryan
4. DATE OF DEATH (Month) (Day) (Year) Sept. 17th 1953					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Mar. 11, 1887	9. AGE (In years last birthday) 66	10. IF UNDER 1 YEAR Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Samuel H. Morton		13b. MOTHER'S MAIDEN NAME Isabel Cutler		14. NAME OF HUSBAND OR WIFE Wm. G. 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. None	17. INFORMANT'S SIGNATURE OR NAME Samuel H. Morton		ADDRESS Above	
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.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Aspiration Pneumonia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive - Cardio-renal - Vascular Disease 12 mo.</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recent Cholecystectomy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>  <u>5 days</u>
19a. DATE OF OPERATION <u>9-12-53</u>	19b. MAJOR FINDINGS OF OPERATION <u>chronic cholecystitis with cholecystitis</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>585X</u>			
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? _____			
22. I hereby certify that I attended the deceased from <u>9-1</u> , 19 <u>53</u> , to <u>9-17</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>9-16</u> , 19 <u>53</u> , and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Michael Dulick</u>			23b. ADDRESS <u>9012 Manchester Rd</u>	23c. DATE SIGNED <u>9-17-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>9-18-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Toronto Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Toronto, Canada</u>		
DATE REC'D BY LOCAL REG. <u>SEP 17 1953</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u> (H.T.) (Licensed Embalmer's Statement on Reverse Side)		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jay B. Smith Funeral Home</u> <u>7456 Manchester, Maplewood, Mo.</u>		

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.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 402  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.