

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7247**

FILED FEB 18 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **590** Registrar's No. **309**

|  |  |  |   |   |  |   |  |   |  |
|--|--|--|---|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>St. Louis</b>   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Mo.</b><br>b. COUNTY |  |   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN<br><b>Pine Lawn</b>   |  | c. LENGTH OF STAY (In this place)<br><b>6 Weeks</b>  |   | c. CITY OR TOWN<br><b>St. Louis</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Shamrock Rest Home</b>   |  |  |   | e. STREET ADDRESS (If rural, give location)<br><b>3626a Shenandoah Ave. 2179 / 1</b>  |  |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First)<br><b>SARAH</b>   |  |  | b. (Middle)<br><b>A.</b>                            |   | c. (Last)<br><b>RYAN</b>   |   | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>Feb. 2 1954</b> |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widow</b>  |  | 8. DATE OF BIRTH<br><b>July 18, 1869</b>  |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 4 HRS.<br><b>84</b> Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Davenport, Iowa</b> |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>James Hanlon</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Flynn</b> |   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Late Cornelius</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Isabella Dunlap 4549a Arco Ave.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |   |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>4200</b>  |   |   |  |   |  | 20. AUTOPSY?<br>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?  |  |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>April 22, 1953</b> , to <b>Feb 2, 1954</b> , that I last saw the deceased alive on <b>Feb 1, 1954</b> , and that death occurred at <b>Noon</b> m., from the causes and on the date stated above. |  |  |   |   |  |   |  |   |  |
| 23a. SIGNATURE, (Degree or title)<br><b>Lewes Littmann MD</b>  |  |  |   | 23b. ADDRESS<br><b>8231 Clayton Rd (17)</b>   |  | 23c. DATE SIGNED<br><b>2/3/54</b>   |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 24b. DATE<br><b>Feb. 5, 1954</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co. Mo.</b>   |  |   |  |
| DATE REC'D BY LOCAL REG.<br><b>2-3-54</b>  |  | REGISTRAR'S SIGNATURE<br><b>Herbert R. Donke M.D.</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Kriegshauser 4228 S.Kingshighway Bl.</b>                                       |  |   |  |   |  |

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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 *Richard W. Storzo*.....

Licensed Embalmer No...40.....

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.