

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11360

State File No. ....

3323

FILED APR 10 1956

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Registrar's No. ....

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF RESIDENCE (Specify place) Oct. 30, 1952 April 2, 1956	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5573 1/2 Lotus Ave. 20670	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) M. c. (Last) Ryan.		4. DATE OF DEATH (Month) (Day) (Year) April 2, 1956	
5. SEX Male.	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 6, 1883
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Fireman	11. BIRTHPLACE (City and State or Foreign Country) St. Louis.
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY St. Louis	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME John F. Ryan.		13b. MOTHER'S MAIDEN NAME Margaret Hughes.	14. NAME OF HUSBAND OR WIFE Nellie
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 ADDRESS Thomas F. Ryan, 10319 St. Joan (14)
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis (b) Chronic Brain Syndrome INTERVAL BETWEEN ONSET AND DEATH years years 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 334X	
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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
18. I hereby certify that I attended the deceased from Oct. 30, 1952, to April 2, 1956, that I last saw the deceased alive on April 2, 1956, and that death occurred at 7:30 A.M., from the causes and on the date stated above.			
22a. SIGNATURE George Esker M.D.		23a. ADDRESS 5800 Arsenal St.	
23b. DATE SIGNED 4/2/56			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/4/56	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. APR 3 1956		REGISTRAR'S SIGNATURE Chas. F. Stuart	
25. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Stuart		ADDRESS 1225 Union Bl.	

(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.....  
Signature of Student Embalmer

Signed *Melvin L. Kerny*.....

Licensed Embalmer No *40*.....

P. O. Address *3505 B*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.