

FILED NOV 22 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42553  
STATE FILE NUMBER  
8206

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

|   |                           |   |  |   |  |
|---|---------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                           |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY St. Louis |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis  |                           | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN Lemay  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br>39 Cardinal Glennon  |                           | Length of stay in 1b<br>2 day   | 27 STREET ADDRESS 7000 Lindberg Rd.  |   | (If outside, give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Kathleen Ryan   |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>SEPT 1 1957  |   |  |
| 5. SEX<br>female  | 6. COLOR OR RACE<br>white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>AUG 30 1957  |   | 9. AGE (In years last birthday)<br>2   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>none   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>none   | 11. BIRTHPLACE (City and state or country)<br>St. Louis, Mo.   |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |
| 13. FATHER'S NAME<br>John T. Ryan   |                           |   | 14. MOTHER'S MAIDEN NAME<br>Florence Lanter  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>no   |                           | 16. SOCIAL SECURITY NO.<br>none   | 17. INFORMANT Address<br>John T. Ryan, 7000 Lindberg Rd.   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Tracheo-esophageal fistula</i><br>Tracheo-esophageal fistula<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>756.2</i> |                           |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>Birth 2 days</i>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY. Hour Month, Day, Year. a. m. p. m.   |                           |   |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE               |  |
| 21. I attended the deceased from <i>Birth</i> to <i>9-1-57</i> and last saw her/him alive on <i>9-1-57</i> . Death occurred at <i>10A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |   |  |   |  |
| 22a. SIGNATURE <i>Robert L. Korn M.D.</i> (Doctor or title) M.D.  |                           |   | 22b. ADDRESS <i>8230 Forsythe</i>  |   | 22c. DATE SIGNED <i>9-2-57</i>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>removal</i>   |                           | 23b. DATE<br><i>9-3-57</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resurrection</i>  |   | 23d. LOCATION (City, town, or county) (State)<br><i>St. Louis Co., Mo.</i>                             |
| 24. FUNERAL DIRECTOR<br><i>Fendler Und. Co. 7420 Michigan</i>   |                           | 25. DATE RECD. BY LOCAL REG.<br><i>SEP 3 '57</i>  |  | 26. REGISTRAR'S SIGNATURE<br><i>J. Earl Smith, M.D.</i> |  |

4 to 5 p.m.

Dr. R. L. Korn

8230 Forsythe  
till 12:00 noon

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Not Embalmed Student Embalmer No. ....

working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed W. G. Peterson

Licensed Embalmer No. 376

P. O. Address 7470 Mich

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