

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

88-034653
STATE FILE NUMBER
9099

FILED OCT 10 1958		Registration District No. 318		Primary Registration District No. 1003		Registrar's No. 9099	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital			Length of stay in lb 2 Days		d. STREET ADDRESS 1305 S. 12th St.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bert Middle Wilson Last Ryan				4. DATE OF DEATH Month 9 Day 19 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 16, 1893	
				9. AGE (In years at birthday) 65		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ambulance Dispatcher			10b. KIND OF BUSINESS OR INDUSTRY Acme Ambulance		11. BIRTHPLACE (City and state or country) Little Rock, Ark. /		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Thomas E. Ryan			13b. MOTHER'S MAIDEN NAME Sarah Stovall			14. NAME OF HUSBAND OR WIFE Mae Francis 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.		17. INFORMANT Address Mrs. Mae Ryan, 1305 S. 12th St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO (b) <i>Anesthesia</i> DUE TO (c) <i>730.2F</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Following operation for</i>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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) <i>ruptured aorta of right leg at City Hospital #1 for September 19th, 1958 at 4:15 p.m.</i>				
20c. TIME OF INJURY Hour 4:15 p.m. Month, Day, Year 9/19/58			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.) <i>23 City Hosp.</i>		
20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <i>4:15 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Wick & Taylor Coroner</i>				22b. ADDRESS <i>1300 Clark Ave</i>		22c. DATE SIGNED <i>9/22/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>9/22/58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Valhalla Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>	
24. FUNERAL DIRECTOR <i>Drehmann-Harral, 1905 Union Blvd.</i>			25. DATE RECD. BY LOCAL REG. <i>SEP 22 '58</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. *Final: -None of the conditions due to anesthesia.* USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Albert P. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *St. Louis*

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.