

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035027  
STATE FILE NUMBER

FILED OCT 3 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2409

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis, Missouri</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hosp.</b>		Length of stay in lb <b>2 Wks.</b>	d. STREET ADDRESS (If outside, give location) <b>5840 Maple Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Francis</b> East <b>Ryan</b>			4. DATE OF DEATH Month <b>9</b> Day <b>16</b> Year <b>58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-30-06</b>		9. AGE (In years last birthday) <b>52</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Parts Assembler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wagner Electric</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Patrick J. Ryan</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Harrington</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If so, of what branch and in what service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>498-032-857</b>	17. INFORMANT Address <b>Mrs. Mary Maender, Florissant Mo.</b>		
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of the Palate = metastases to the cervical lymph nodes causing Tracheal + Esophageal Obstruction</b> DUE TO (b) <b>the cervical lymph nodes</b> DUE TO (c) <b>causing Tracheal + Esophageal Obstruction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>144X</b>					INTERVAL BETWEEN ONSET AND DEATH
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 <b>4:00</b> a.m. <b>PM</b> Month, Day, Year <b>9-2-58</b>					
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 Death occurred at <b>4:00 PM 9-2-58</b> , to <b>16 Sept 58</b> and last saw him live on <b>14 Sept 58</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>James P. Donke, M.D.</b>			22b. ADDRESS <b>3720 Washington Ave.</b>		22c. DATE SIGNED <b>22 Sept 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>9-19-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>White-Mullen 118 N. Florissant Rd.</b>			25. DATE RECD. BY LOCAL REG. <b>9-18-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert P. Donke M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Eleanora Povince

Licensed Embalmer No. 3402

P. O. Address: Janney St

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.