

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011349
STATE FILE NUMBER

REG MAR 17 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2096**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Franklin			
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 Lone Dell	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital		Length of stay in 1b		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Patrick Middle _____ Last Ryan			4. DATE OF DEATH Month February Day 25 Year 1959		
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 August 12, 1883		9. AGE (In years last birthday) 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lone Dell, Mo.	
13a. FATHER'S NAME Patrick Ryan		13b. MOTHER'S MAIDEN NAME Ellen Dunlevy		14. NAME OF HUSBAND OR WIFE Cora	
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. Unknown		17. INFORMANT Address Cora Ryan, Lone Dell, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion Myocardial infarction DUE TO (b) Arteriosclerosis DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 16 hrs
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 <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.) 109		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2:25 AM to 2/25/59 and last saw ^{heard} him alive on 2/25/59 Death occurred at 1:48 pm m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Roland S. Keffer M.D. (Degree or title)			22b. ADDRESS 100 N. Euclid St. Morris		22c. DATE SIGNED 2/27/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-28-59	23c. NAME OF CEMETERY OR CREMATORY Old Rock Church Cemetery		23d. LOCATION (City, town, or county) (State) Catawissa, Mo.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. ADDRESS			25. DATE RECD. BY LOCAL REG. FEB 27 '59		26. REGISTRAR'S SIGNATURE Roland Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All entries 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 *E. J. Remick*

Licensed Embalmer No. *4283*
P. O. Address *St. Louis, Mo.*

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.