

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6658**

61-027297
STATE FILE NUMBER

FILED JUL 26 1961

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. | | Length of stay in 1b 16 Days | | c. CITY OR TOWN Florissant | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1115 St. Patrice Lane | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Francis Middle J. Last Ryan | | | | 4. DATE OF DEATH Month July Day 14 Year 1961 | | | | | |
| 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 5-17-1907 | | 9. AGE (last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME Thomas Ryan | | | 13b. MOTHER'S MAIDEN NAME Anna Ford | | | 14. NAME OF HUSBAND OR WIFE Helen E. Ryan | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 17. INFORMANT Address Helen E. Ryan 1115 St. Patrice Lane | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO (b) _____ DUE TO (c) 162-1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 MOS | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ s.m. _____ p.m. Month, Day, Year _____ | | 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 12-1-61 to 7-14-61 and last saw him alive on 7-14-61 Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE William Seese (Degree or title) | | | | 22b. ADDRESS 3720 Washington | | | 22c. DATE SIGNED 7-17-61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7-18-1961 | | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Collier Mortuary ADDRESS St. Ann, Mo. | | | | 25. DATE RECD. BY LOCAL REG. JUL 17 1961 | | 26. REGISTRAR'S SIGNATURE Loed Smith, M.D. | | | |

DATE AMENDED
INSTEAD OF
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann

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.