

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-035442

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2572

AMENDED

FILED SEP 18 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ladue		Length of stay in 1b 10 YRS	c. CITY OR TOWN Ladue Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10049 Conway Rd.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 10049 Conway Rd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First KATHRYN Middle AGNES Last RYAN			4. DATE OF DEATH Month Sept Day 11 Year 1961	
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1890	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months 8 Days 22	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman	10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (City and state or country) Litchfield, Ill	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Patrick Ryan	13b. MOTHER'S MAIDEN NAME Elleanor Sheridan	14. NAME OF HUSBAND OR WIFE -----
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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 Eleanor Ryan 10049 Conway Rd.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>4200</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/3 hrs</u> <u>years</u>
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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.)
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20c. TIME OF INJURY Hour a.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 <u>7-25-60</u> to <u>9-11-61</u> and last saw her alive on <u>9-11-61</u> Death occurred at <u>10:20 am</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>John H. Muehler MD</u>	22b. ADDRESS <u>950 Francis Place Clayton</u>	22c. DATE SIGNED <u>9-12-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE Sept. 13, 1961	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	23d. LOCATION (City, town, or county) (State) Litchfield, Ill.
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24. FUNERAL DIRECTOR ADDRESS A. H. Bocklage 6536 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 9-12-61	26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>
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ITEM NO. SHOULD READ

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 John J. Haines

Licensed Embalmer No. 4108

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.