

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-029119

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

6504

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED JUL 31 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. LOUIS, MO.</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		c. CITY OR TOWN <u>St Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS CITY HOSP.#1</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>6518 Odell</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle Last <u>RYAN</u>			4. DATE OF DEATH Month <u>7</u> - Day <u>14</u> - Year <u>62</u>			5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-87</u>		9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Unknown</u>						13b. MOTHER'S MAIDEN NAME <u>Unknown</u>						14. NAME OF HUSBAND OR WIFE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>						16. SOCIAL SECURITY NO.						17. INFORMANT <u>Edward Ryan</u> Address <u>10236 Monard</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH <u>2+ wks</u>							
IMMEDIATE CAUSE (a) <u>CARDIAC DeCOMPENSATION</u>																			
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>												<u>2 YEARS</u>							
DUE TO (c) <u>Cerebral Artsch. &amp; Chronic Brain Syndr.</u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension, Arterioalar Nephrosclerosis</u>												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 type="checkbox"/>		20a. ACCIDENT		SUICIDE		HOMICIDE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)											
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>7-2-62</u> to <u>7-14-62</u> and last saw her/him alive on <u>7-14-62</u> Death occurred at <u>2:45 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE <u>Jay Meyer, M.D.</u> (Degree or title)						22b. ADDRESS <u>1515 LAFAYETTE</u>						22c. DATE SIGNED <u>7-16-62</u>							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>7/16/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Peter &amp; Paul</u>				23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>											
24. FUNERAL DIRECTOR <u>John Stiggardson</u> ADDRESS <u>5541 River</u>						25. DATE RECD. BY LOCAL REG. <u>JUL 16 1962</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>											

USE BLACK INK OR TYPEWRITER RIBBON

**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 JW Ruster

Licensed Embalmer No. 3980

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.