

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registered on List **318** Primary Registration District No. **1003** Registrar's No. **9277**

-62-036667
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF

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		Length of stay in lb Years	c. CITY OR TOWN University City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 855 Westgate Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First IDA Middle B. Last RYAN		4. DATE OF DEATH Month Sept. Day 24 Year 1962	
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 12-1-1884
9. AGE (last birthday) 77		IF UNDER 1 YEAR Months 77 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Fulton Iron Works	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Patrick Ryan	
13b. MOTHER'S MAIDEN NAME Bridget Foley		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. LA	
17. INFORMANT Walter P. Ryan		Address 3591 Heathrick St. Jacksonville Fla.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction			INTERVAL BETWEEN ONSET AND DEATH 29 1/2
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adeno Carcinoma of Cecum			6 mo
DUE TO (c) 153.0			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. Malnutrition & Advanced Age			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.)	
20c. TIME OF INJURY Hour 3:30 a.m. p.m. Month, Day, Year 9/24/62	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 St. Louis COUNTY St. Louis STATE Missouri
21. I attended the deceased from 9/24/62 to 9/24/62 and last saw her/him alive on 9/24/62 Death occurred at 8:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE Louise Stephens M.D. (Degree or title)		22a. ADDRESS 834 N. Grand Ave	
22c. DATE SIGNED 9/26/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 27, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri (Site)
24. FUNERAL DIRECTOR Lupton Chapel Inc. 7233 Delmar		25. DATE RECD. BY LOCAL REG. SEP 26 1962	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

*Mr. Stephens will comply
and sign.*

*Ryan
City Clinic*

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.