

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030747

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2251

STATE FILE NUMBER

FILED JUL 22 1963

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

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY St. Louis county		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 any) OR TOWN Des Peres		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chastains, Inc.		d. STREET ADDRESS (If outside, give location) 439 Belleview	
3. NAME OF DECEASED (Type or print) First Alice Middle Ryal Last Franklin		4. DATE OF DEATH Month July Day 14 Year 1963	
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/10/77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Joseph Franklin		13b. MOTHER'S MAIDEN NAME June Ann Ryal	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) no		17. INFORMANT Miss Florence Johnson, 916 Leonard Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of colon			INTERVAL BETWEEN ONSET AND DEATH 4 years
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.)	
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 May 1953 to 7/14/63 and last saw her alive on 7/13/63 Death occurred at 12:30 10 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Carl Brand MD		22b. ADDRESS Webster Groves Mo	22c. DATE SIGNED 7/15/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/16/63	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Mo.
24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich, Webster Groves, Mo.		25. DATE RECD. BY LOCAL REG. 7-15-63	26. REGISTRAR'S SIGNATURE [Signature]

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 Van M. Szanos

Licensed Embalmer No. 4343

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.