

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

37939

1928

1. PLACE OF DEATH

County St. Charles Registration District No. 757 File No. _____
 Township _____ Primary Registration District No. 3036 Registered No. 184
 City St. Charles (No. 619 South Second) St. _____ Ward _____

2. FULL NAME Matthew Jerome Ryan

(a) Residence. No. 619 N. Second St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 6 yrs. 3 mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 27, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 10 | 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work A Religious of the Sacred Heart
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) New Orleans
 (STATE OR COUNTRY) Louisiana

10. NAME OF FATHER Matthew Ryan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) I do not know
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Julia Hayes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) I do not know
 (STATE OR COUNTRY) _____

14. INFORMANT Madame Catherine Weres
 (Address) Consent, Sacred Heart, St. Charles

15. FILED 12-6, 1927. Otto Beckenauer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4th 1927

17. I HEREBY CERTIFY, That I attended deceased from November 30, 1927 to December 4, 1927 that I last saw h. w. alive on Dec 4th 1927, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio Sclerosis -
Amyloid heart valves &
92 Endocarditis
106B (duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Bronchitis & emphysema
97 (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF BIRTH, _____

19. DID AN OPERATION PRECEDE DEATH. no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Quincke's sign
 (Signed) B. P. W. Gutter, M. D.
125, 1927 (Address) St. Charles Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sacred Heart Cemetery DATE OF BURIAL Dec 6 1927

20. UNDERTAKER W. H. Almyer & Sons Co ADDRESS St. Charles Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

