

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

Do not use this space.

31930

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City St. Louis (No. 3933 W. Pine Blvd)

File No.....
Registered No. 9190
St. Ward)

2. FULL NAME

(a) Residence. No. John F Ryan St., 19 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

Male White Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt 39 Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teller
(b) General nature of industry, business, or establishment in which employed (or employer) Federal Reserve Bank
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

10. NAME OF FATHER John F Ryan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Jane Riley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs Jane Ryan (Address) 3933 W Pine

15. FILED SEP 14 1927 My C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/14 1928

17. I HEREBY CERTIFY, That I attended deceased from March, 1928, to Sept 14, 1928 that I last saw h. l. alive on 9-14-28, 1928, and that death occurred, on the date stated above, at 4:15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Peritonitis
T.B.
T.P.
hip - (duration) 3 yrs. 3 mos. 3 da.
CONTRIBUTORY Tuberculosis of Left (SECONDARY) hip - (duration) 33 yrs. 3 mos. 3 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF.....
WAS THERE AN AUTOPSY? no
WHAT BEST CONFIRMED DIAGNOSIS? Chronic of the Ray -
(Signed) H. F. Glaze, M. D.
, 19 (Address) 912 Beaumont Bldg.

*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 DATE OF BURIAL

Calvary Cemetery 9/15 1928

20. UNDERTAKER ADDRESS
Arthur J. Donnelly 2039 Wash St

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.

3720 Washington

Jeff 6720 102

Forest 6781