

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

Do not use this space.

4208

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003** File No.
 City St. Louis (No. One House 4th St.) Registered No. **832**
 Ward

2. FULL NAME

Michael Ryan
 (a) Residence. No. 309 M. Anthony St. 22 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Do Not Know</u>		
7. AGE YEARS <u>About 75</u>	MONTHS —	DAYS —
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Composition Profes</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>St. Charles Mo</u>		
10. NAME OF FATHER <u>Unknown</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>		
12. MAIDEN NAME OF MOTHER <u>Unknown</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>		
14. INFORMANT (Address) <u>Shed Kises 4142 Iowa</u>		
15. FILED <u>at St. Louis</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 15 1929

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on..... 19..... and that death occurred, on the date stated above, at 5:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
935 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) W.M.A. (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 900

8 DID AN OPERATION PRECEDE DEATH? NO DATE OF WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. W. Kerner, M.D.
117 29 (address) Dep. Comm

*State the DISEASE CAUSING DEATH, on 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 Calvary DATE OF BURIAL JAN 19 1929

20. UNDERTAKER Mr. Collins ADDRESS 828 N. Grand

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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