

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.

JUN 23 1933

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

Do not use this space.

1. PLACE OF DEATH
 County St. Louis Co. Registration District No. 1123
 Township Manchester Primary Registration District No. 6248 B.
 City Koch Hosp. No. _____ St. _____ Ward _____

2. FULL NAME James Ryan (alias) Culbertson
 (a) Residence, No. 1014 N. 15th St. Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

File No. 17758
 Registered No. 162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 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) June 24 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris

MOTHER 13. NAME Grant Ryan
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass.

FATHER 15. MAIDEN NAME Anne Bunsbury
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Koch Hospital Records
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Orie Penn DATE May 22 1933

19. UNDERTAKER H. W. Wiedersfeld
 (ADDRESS) 435 N. 9th St.

20. FILED May 20, 1933 E. J. St. Louis
2. G. Abbott M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19 1933

2. I HEREBY CERTIFY, That I attended deceased from May 6 1933 to May 19 1933
 I last saw him alive on May 19 1933 Death is said to have occurred on the date stated above, at 7 a. m.
 The principal cause of death and related causes of importance were as follows:
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Pne Tuberculosis
See list
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Carroll J. Leonard, M. D.
 (Address) Koch Hosp.

