

Registration District No. 791
1003

Primary Registration District No. _____

1. PLACE OF DEATH:

- (a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution St. Paul's
(d) Length of stay: In hospital or institution 5 hours
In this community _____ years, months or days

RECEIVED SEP 14 1939

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 6510 Woodrow
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME HELEN RYAN

8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Sept 8, 1903
(Month) (Day) (Year)

8. AGE: Years 35 Months 10 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Burkhardt

13. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

14. Maiden name Anna Burkhardt

15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James Ryan

(b) Address 6510 Woodrow

17. (a) Burial (b) Date thereof Aug 4, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. F. W. ...

(b) Address 1389 Union

19. (a) AUG 3 1939 (b) J. F. W. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day first
year 1939 hour 9 minute 26 M.

21. I hereby certify that I attended the deceased from 12-24
1938 to 8-1-39

that I last saw him alive on 8-1-39
and that death occurred on the date and hour stated above.

Immediate cause of death Post-partum shock
Terminal cardiac failure
Due to _____

Duration

1 hr
1 hr

Due to _____

Other conditions Pregnancy
(include pregnancy within 3 months of death)

Major findings: Of operations X

Of autopsy X

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. A. Lusche (M. D. or other Med)

Address 4885 Natural Bridge Date signed 8-3-39

WHITE PAPER—USE UNFADING BLACK INK—MAKE 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.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed..... *Ben Ferrin*

Licensed Embalmer No. 1591

P. O. Address.....

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 this body is not embalmed, above space should be left blank.