

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Alexian Bro Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: **15 Min**
In this community **Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County _____
(c) City or town **St. Louis** **13**
(If outside city or town limits, write "RURAL")
(d) Street No. **3449 Taft Ave**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **Life** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **29th.**
year **1940** hour **7:20: PM** minute _____ M.

21. I hereby certify that I attended the deceased from **11-13-40** to **12-29-40**
that I last saw him alive on **12-24-40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral hemorrhage**
Due to **high blood pressure**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations _____
Of autopsy **su**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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)
(a) Means of injury _____
23. Signature **Loyal L. Ferris** (M. D. or other) _____
Address **4065 So Grand** Date signed **12/30/40**

8. (a) PRINT FULL NAME **William F Ryan**

8. (b) If veteran, name war _____ 8. (c) Social Security No. **488-07-7931**

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

6. (b) Name of husband or wife **Mary** 6. (c) Age of husband or wife if alive **57** years

7. Birth date of deceased **Sept 1st. 1883**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 **3** **29** hr. _____ min.

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

10. Usual occupation **Shoemaker**

11. Industry or business **International Shoe Co**

12. Name **David Ryan**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Johanna O'Brien**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Mary Ryan**

(b) Address **3449 Taft Ave.**

17. (a) **Burial** (b) Date thereof **1/2/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemt Ass'n**

18. (a) Signature of funeral director **Harrigan & Sheahan Und Co**

(b) Address **4415 Washington Blvd.**

19. **DEC 31 1940** (b) **J. J. Brudeck**
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

*Dr. Homer
No 618 Hancock*

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: *Homer H. Britz*

Licensed Embalmer No. *3882*

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.