S. No. 2
M—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15539

FILED JUN 9 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4767

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home G. Phillips
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. St Ferdinand Avenue 4241 W.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ollie Ryan

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William Ryan

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Aug. (Month) 24, (Day) 1902 (Year)

8. AGE:

Years	Months	Days	If less than one day
42	9	0	hr. min.

9. Birthplace Panther Burn, (City, town, or county) Miss. (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henderson Miller
13. Birthplace Panther Burn, (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Corine ?
15. Birthplace Milver, (City, town, or county) Miss. (State or foreign country)

16. (a) Informant William Ryan
(b) Address 4241 W. St Ferdinand Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 45 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Dement & Son
(b) Address 2629-31 Cole Street

19. (a) MAY 29 1945 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1945 hour 9 minute 35 A M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Brain Abscess; Fracture of Neck of Left Femur; suffered when deceased fell to the floor at the Homer Phillips Hospital on May 8 1945;

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Accident

(b) Date of occurrence May 8, 1945

(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?
Hospital
(Specify type of place)

While at work? (e) Means of injury Same

23. Signature Patrick E. Taylor (M.D. or other)

Address Date signed 6/29/45

(Licensed Embalmer's Statement on Reverse Side)

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 W Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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, fact should be so stated above.