

FILED AUG 18 1945
Registration District No. **327**

Primary Registration District No. **3069**

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

1. PLACE OF DEATH: **St. Louis**

(a) County: **St. Louis**

(b) City or town: **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Mary's Hospital**
(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

3. (a) PRINT FULL NAME: **Bro. John Michael Ryan S.J.**

3. (b) If veteran, name war: **Spanish Am. War**

3. (c) Social Security No.: **None**

4. Sex: **Male**

5. Color or race: **White**

6. (a) Single, widowed, married, divorced: **Single**

6. (b) Name of husband or wife: _____

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

7. Birth date of deceased: **July 4th, 1871**
(Month) (Day) (Year)

8. AGE: Years **74** Months **1** Days **10** If less than one day _____ hr. _____ min.

9. Birthplace: **Canada**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Religious in the Jesuit Order**

11. Industry or business: **John Ryan**

MOTHER FATHER

12. Name: **John Ryan**

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

14. Maiden name: **Catherine**

15. Birthplace: **New York**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Bro. A.A. Knoll S.J.**

(b) Address: **Florissant Mo.**

17. (a) **Burial** (b) Date thereof: **8-17-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **St. Stanislaus Cem.**

18. (a) Signature of funeral director: **Jos. W. Clark**

(b) Address: **1125 Hodiadont Ave**

19. (a) **8-16-45** (b) **E. B. D. Larson M.D.**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **St. Louis**

(c) City or town: **Florissant**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **14th.** year **1945** hour **7.30** minute **A.M.**

21. I hereby certify that I attended the deceased from **July 25** 19**45** to **Aug 14** 19**45**
that I last saw him alive on **July 25** and that death occurred on the **14th** and our stated above.

Immediate cause of death: **Heat Stroke**

Duration _____

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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) _____

(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) (c) Means of injury _____

23. Signature: **J. J. Hunter** (M. D. or other) _____

Address: **Hughes St Bldg** Date signed: **Aug 15-45**

Dr. F.J. Tainter

539 N. Grand Ave

Je. 8128

1-3-81/44

AUG 30 1945

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

Alfred J. Boedeker

Licensed Embalmer No.

2663

P. O. Address

5934 Alpha

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.