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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. **19320**

FILED JUN 5 1947 318

Registration District No. _____ Primary Registration District No. **1003** Registrar's No. **5145**

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthonys 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 Patrick Ryan

3. (b) If veteran, name war X 3. (c) Social Security No. X

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 May 21 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 3 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Everett L. Ryan

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

14. Maiden name Lorraine Kuntz

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

16. (a) Informant Everett Ryan
(b) Address 4141 Beethoven

17. (a) burial (b) Date thereof 5/23/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Peter & Paul Cem
18. (a) Signature of funeral director J L Ziegenhein & Sons
(b) Address 7027 Gravois

19. (a) MAY 23 1947 (b) J. F. Brueck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4141 Beethoven
15 (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 21 day 21st
year 1947 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 21
1947 to May 21, 1947
that I last saw him alive on May 21, 1947, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
TERTORIAL BRAIN Hemorrhage

Due to Birth injury

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

Major findings:
Of operations _____

Of autopsy TERTORIAL BRAIN Hemorrhage

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

(c) 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 _____

Signature Robert W. Tichenor (M. D. or other) M.D.
Address 4602 Gravois Ave. Date signed May 22/47

(Licensed Embalmer's Statement on Reverse Side) Robert W. Tichenor

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..... *Frank Owens*

Licensed Embalmer No. *2245*

P. O. Address *St. Louis Mo.*

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.