

V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22618

FILED JUN 23 1947

State File No.

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5832**

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

17
9

1. PLACE OF DEATH:

(a) County St. Louis Mo

(b) City or town St. Louis Mo

(c) Name of hospital or institution: Barnes Hospital, 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 13 hrs (Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Daniel Cletus Ryan

3. (b) If veteran, name war ✓

3. (c) Social Security No. no

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife UNKNOWN

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

7. Birth date of deceased: APRIL 12 1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 2 If less than one day ✓ hr. ✓ min.

9. Birthplace ASSUMPTION ILLINOIS (City, town, or county) (State or foreign country)

10. Usual occupation UNKNOWN

11. Industry or business UNKNOWN

MOTHER FATHER

12. Name JOHN RYAN

13. Birthplace UNKNOWN IRELAND (City, town, or county) (State or foreign country)

14. Maiden name MARY MEGAN

15. Birthplace UNKNOWN IRELAND (City, town, or county) (State or foreign country)

16. (a) Informant John McManus

(b) Address TAYLORVILLE, ILL.

17. (a) REMOVAL (b) Date thereof JUNE 16, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. MARY'S CHURCH ASSUMPTION, ILL.

18. (a) Signature of funeral director B. J. Lamb

(b) Address Jayville Ill

19. (a) JUN 14 1947 (b) J. F. Bradick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State ILL. (b) County CHRISTIAN

(c) City or town ASSUMPTION, ILL
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14 year 1947 hour 12 minute 40 A.M.

21. I hereby certify that I attended the deceased from Nov. 29 1946 to June 14 1947; that I last saw him alive on June 14 1947; and that death occurred on the date and hour stated above.

Immediate cause of death acute heart failure Duration 1 hr.

Due to arteriosclerotic heart Disease 5 yrs. and aplastic anemia 3 yrs.

Due to unknown cause

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

Major findings: Of operations _____

Of autopsy acute dilatation of the heart, arteriosclerosis, Pulmon. Edema, Hemochromatosis, Gall stones

PHYSICIAN

Underline the cause to which death should be charged

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) (e) Means of injury 0

23. Signature J. F. Perry (M. D. certificate)

Address Barnes Hospital Date signed 6/15/47

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..... *B. J. Leach*

Licensed Embalmer No. *7149* *Illin*

P. O. Address *Taylorville, Ill*

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.