

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis  
(c) Name of hospital or institution:  
St. Johns Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... 9-years  
In this community..... 25 yrs.  
years, months or days

3. (a) PRINT FULL NAME..... Mary Ryan  
3. (b) If veteran, name war.....  
3. (c) Social Security No. ....

4. Sex Female / 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..... Feb. 14th., 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
68 0 13 hr. min.

9. Birthplace Newport Ky.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business.....

12. Name John Ryan

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

14. Maiden name Bridget Quinn

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

16. (a) Informant Mr. James P. Ryan

(b) Address Danielson, Conn.

17. (a) Removal (b) Date thereof 3-2-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newport Ky.

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd

19. (a) MAD 1 (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Mo. (b) County..... 000  
(c) City or town..... St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No..... St. Johns Hospital (Residence)  
(If rural, give location)  
(e) Citizen of foreign country?..... 9  
(Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 27th  
year 1948 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from 2-24-48  
to 2-27, 1948,  
that I last saw her alive on 2-27, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Arterio sclerotic cardiac  
vascular dis.  
Duration years

Due to Internal hemorrhage  
gastro intestinal cause 2 days

Due to.....  
Other conditions none  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations..... none  
Of autopsy..... none  
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) no  
(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.....

23. Signature John J. Haunmond (M. D. or other) M.D.  
Address 684 N. Grand Date signed 2/28/48

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

MOTHER FATHER

Dr. John Thomas and  
The Thacker Society

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**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 H Van Matre  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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.**