

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 5 1949

State File No. **25244**  
**6545**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>11</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b> <b>91</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1811A OREGAN</b>		d. STREET ADDRESS (If rural, give location) <b>23-1811A Oregon Av</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>EDWARD</b>	b. (Middle) <b>J.</b>	c. (Last) <b>RYAN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JULY 27-49</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>AUG-1-1895</b>	9. AGE (In years last birthday) <b>53 YRS</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTH PLACE (State or foreign country) <b>ST. LOUIS MO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>EDWARD P. RYAN</b>	13b. MOTHER'S MAIDEN NAME <b>MARGARET M. GRATH</b>	14. NAME OF HUSBAND OR WIFE <b>ELIZABETH RYAN</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Elizabeth Ryan</b>	ADDRESS <b>1811<sup>a</sup> Oregon</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension present 1-10-49</b> DUE TO (c) <b>Nephritis present 1-10-49.</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>10 MO</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>HIT BY CAR</b>

22. I hereby certify that I attended the deceased from **7-21-49** to **7-27-49**, that I last saw the deceased alive on **7-25-49**, and that death occurred at **4:30** p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>John W. Lynn</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>1715 So 39th St. St. Louis Mo</b>	23c. DATE SIGNED <b>7-28-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>JULY 29-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEM.</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>
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DATE REC'D BY LOCAL REG. <b>JUL 28 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Foster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Schurr</b>	ADDRESS <b>3125 Lafayette</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*Joseph Ballmer*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*484  
3125 Lafayette*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.