

FILED JUL 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25206
6424

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 MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 20 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		2229	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION MO. PACIFIC HOSP.				d. STREET ADDRESS (If rural, give location) 3266 Hickory St.			
3. NAME OF DECEASED (Type or Print) a. (First) THOMAS		b. (Middle) _____		c. (Last) RYAN		4. DATE OF DEATH (Month) (Day) (Year) JULY 17 1951	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH 11/26/86	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) IRELAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? 4	
13a. FATHER'S NAME EDWARD RYAN		13b. MOTHER'S MAIDEN NAME SARAH BURKE		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS SARAH McDONALD 606th HICKORY ST.			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation ANTECEDENT CAUSES Carcinoma of pharynx and larynx Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 7 mo. 7 mo.	
19a. DATE OF OPERATION 6/28/51 7/3/51		19b. MAJOR FINDINGS OF OPERATION Tracheotomy Gastrostomy				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. HOW DID INJURY OCCUR? 148X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from 6/27, 1951 , to 7/17, 1951 , that I last saw the deceased alive on 7/17, 1951 , and that death occurred at 9:45 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE Bart M. Passavant, M.D.				23b. ADDRESS ST. Louis, Mo. 1755 S. Grand Ave.		23c. DATE SIGNED 18 July 51	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE BURIAL JUL 21, 1951		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.		24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	
DATE REC'D BY LOCAL REG. JUL 18 1951		REGISTRAR'S SIGNATURE J. B. Fawcett		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Blavier			

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

Homer C. Dill

Licensed Embalmer No.

4347

P. O. Address

1906 Graves

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.