

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35569
State File No. 9059

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hosp.		f. STREET ADDRESS (If rural, give location) 5089 Washington	

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) c. (Last) Ryan			4. DATE OF DEATH (Month) (Day) (Year) Oct. 14 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never married	8. DATE OF BIRTH Jan. 8-1871	9. AGE (In years last birthday) 80	# UNDER 1 YEAR Months # UNDER 1 YEAR Days # UNDER 1 YEAR Hours # UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Matthew J. Ryan		13b. MOTHER'S MAIDEN NAME Nancy Lawrence		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles M. Ryan 7158 Pershing	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. Nephritis			INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
		ANTECEDENT CAUSES DUE TO (b) Chr. Myocarditis DUE TO (c) Arteriosclerosis			1 yr	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophy of Prostate Gland			many years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H22.1	

22. I hereby certify that I attended the deceased from April, 1951, to 10/14/51, 19__, that I last saw the deceased alive on 10/14/51, 19__, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE G. William Porell M.D.		(Degree or title)		23b. ADDRESS 4930 Lindell Bl.		23c. DATE SIGNED 10/15/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-17-51		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis, Mo	

DATE REC'D BY LOCAL REG. OCT 15 1951		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washinton	
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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

John J. Haines

Licensed Embalmer No. *4108*

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.