

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39661**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9908**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 55-yrs.		d. STREET ADDRESS (If rural, give location) 933 Buena Vista	
d. FULL NAME OF HOSPITAL OR INSTITUTION 933 Buena Vista			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) John	b. (Middle) Arthur		c. (Last) Ryan		Nov. 7, 1951	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Mar. 7, 1886	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 8 Days 0	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Business		10b. KIND OF BUSINESS/OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Moberly, Mo.		12. CITIZENRY OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Ryan		13b. MOTHER'S MAIDEN NAME Mary Julia Turner		14. NAME OF HUSBAND OR WIFE Mrs. Stella Ryan	
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 Mrs. Stella Ryan, 933 Buena Vista	
ADDRESS					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis chr		DUE TO (b) Hypertension			2 days approx
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Diabetes Mellitus			?
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"/>

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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 260X	

22. I hereby certify that I attended the deceased from Jan 11, 1951, to Nov. 7, 1951, that I last saw the deceased alive on Nov 5, 1951, and that death occurred at 10:45 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. W. H. Smith, M.D.		23b. ADDRESS 4800 Olive St.		23c. DATE SIGNED 11-8-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 10, 1951		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. 10/18		REGISTRAR'S SIGNATURE J. E. Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	
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(Licensed Embalmer's Statement on Reverse Side)

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

0.300
0.48

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.....

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.