

FILED MAR 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6742**
Registrar's No. **1488**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE - Mo. b. COUNTY	
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) Life		d. STREET ADDRESS (If rural, give location) 6049 McPherson Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6049 McPherson Ave.		5	
3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) c. (Last) Ryan		4. DATE OF DEATH (Month) (Day) (Year) Feb. 15, 1952	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 20, 1868
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Michael W. Meagher	
13b. MOTHER'S MAIDEN NAME Mary Delaney		14. NAME OF HUSBAND OR WIFE Lancelot Ryan	
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.	
17. INFORMANT'S SIGNATURE OR NAME James L. Meagher		ADDRESS 6049 McPherson Av	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis ANTECEDENT CAUSES 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. Fractured left hip 2/16/52		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
19a. DATE OF OPERATION Jan 15	19b. MAJOR FINDINGS OF OPERATION Fractured hip - Fall 500		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT None	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis	21f. HOW DID INJURY OCCUR? at home	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1 13 5V A m.	21e. INJURY OCCURRED WHILE AT WORK WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21g. E9040-21		
22. I hereby certify that I attended the deceased from 1-15, 1952 , to 2-15, 1952 , that I last saw the deceased alive on 2-10, 1952 , and that death occurred at 8A m. , from the causes and on the date stated above.				
23a. SIGNATURE Thomas W. Martin		23b. ADDRESS 634 No Grand	23c. DATE SIGNED 2/15/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-18-52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. FEB 16 1952	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		

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 _____

William 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.