

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23131**
Registrar's No. **5696**

FILED JUN 26 1953

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

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, | | c. LENGTH OF STAY (In this place) | c. CITY OR TOWN Richmond Heights d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital | | e. STREET ADDRESS (If rural, give location) 1505 Bredell Ave. | |

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| 3. NAME OF DECEASED (Type or Print) | a. (First) JOHN | b. (Middle) Patrick | c. (Last) RYBURN. | 4. DATE OF DEATH (Month) (Day) (Year) June 8, 1953 |
|-------------------------------------|------------------------|----------------------------|--------------------------|---|

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|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-----------------------|-----------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Aug. 30, 1893 | 9. AGE (In years last birthday) 59 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours | IF UNDER 15 MIN. Min. |
|--------------------|-------------------------------|---|---------------------------------------|---|------------------------|----------------------|-----------------------|-----------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | 10b. KIND OF BUSINESS OR INDUSTRY Medical & Surgical. | 11. BIRTHPLACE (City and State or Foreign Country) Meadow View, Va. | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME Samuel Logan Ryburn. | 13b. MOTHER'S MAIDEN NAME Emily Larimer | 14. NAME OF HUSBAND OR WIFE Loretta Ryburn |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) yes W.W.I | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Loretta Ryburn | ADDRESS Richmond Heights |
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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, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis | | |
| | ANTECEDENT CAUSES Morbidity 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. | | | |

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| 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) |
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| 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? 4201 |
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22. I hereby certify that I attended the deceased from **6-7, 1953**, to **6-8, 1953**, that I last saw the deceased alive on **6-8, 1953**, and that death occurred at **2:35 A.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE P. D. Neugebauer M.D. (Degree or title) | 23b. ADDRESS 404 1/2 Taylor | 23c. DATE SIGNED 6-8-53 |
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|---|----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 6-11-1953 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cem. | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| DATE REC'D BY LOCAL REG. JUN 8 1953 | REGISTRAR'S SIGNATURE Paul Smith M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons | ADDRESS 7233 Delmar Blvd. |
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *Arnold W. Schoena*

Licensed Embalmer No. *386*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.