

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21181

State File No. ....

Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. ....		Registrar's No. <b>4532</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri.</b> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>0</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <b>0</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>4238 N. Euclid Ave.,</b>							
3. NAME OF DECEASED (Type or Print) a. (First) <b>Celeste</b>			b. (Middle) <b>G.</b>			c. (Last) <b>Ryan</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 17 1954</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>April 13, 1892</b>		9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo. 0</b>			12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME <b>Louis Eichenauer</b>				13b. MOTHER'S MAIDEN NAME <b>Nellie Grace</b>				14. NAME OF HUSBAND OR WIFE <b>George A. Ryan (decd)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>George A. Ryan, 4238 N. Euclid</b>					
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) <b>Metastatic carcinoma</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Carcinoma of breast</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 <b>1 1/2 yrs</b> <b>1 1/2 yrs</b>			
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? <b>170X</b>							
22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>53</b> , to <b>May 17</b> , 19 <b>54</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>11:20 P.M.</b> , from the causes and on the date stated above.											
23a. SIGNATURE <b>J. J. Cassidy / C. W. Womack</b>				(Degree or title) <b>MD</b>		23b. ADDRESS <b>539 N Grand</b>			23c. DATE SIGNED <b>5-20-54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-21-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>					
DATE REC'D BY LOCAL REG. <b>MAY 20 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Cullinane Bros</b>		ADDRESS <b>3320 N. Kingshighway</b>					

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

(Licensed Embalmer's Statement on Reverse Side)

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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..... *Fred Frick*

Licensed Embalmer No.... 3186

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.