

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003458
STATE FILE NUMBER
285

FILED JAN 28 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 285

300
1-57
32
037

| | | | |
|--|--|---|---|
| 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, give TOWNSHIP only) OR St. Louis TOWN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital | | Length of stay in 1b 1 week | 5037 STREET ADDRESS 6032 Juniata Avenue (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First Dorothy Middle Eather Last Ryan | | | 4. DATE OF DEATH Month Jan. Day 8 Year 1959 | | |
|---|--|--|---|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|---|--|---|--------------------------------|
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 27, 1908 | 9. AGE (In years last birthday) 50 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
|-------------------------|----------------------------------|---|---|--|---|--------------------------------|

| | | | |
|---|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) St. Louis, Missouri | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|---|--|--|

| | | |
|--|---|--|
| 13a. FATHER'S NAME Harmon Cherry | 13b. MOTHER'S MAIDEN NAME Annie Kenny | 14. NAME OF HUSBAND OR WIFE Thomas B. 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. 488-10-3807 | 17. INFORMANT Thomas B. Ryan, 6032 Juniata Avenue Address |
|---|---|--|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas | | INTERVAL BETWEEN ONSET AND DEATH 1 yr |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 157x | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

| | |
|---|--|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
|---|--|

| | | | |
|---|--|--|--|
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ |
|---|--|--|--|

| |
|---|
| 21. I attended the deceased from July 29, 1958 to Jan. 8, 1959 and last saw her alive on Jan. 7, 1959 Death occurred at 5:05 AM on the date stated above; and to the best of my knowledge, from the causes stated. |
|---|

| | | |
|---|-------------------------------------|-----------------------------------|
| 22a. SIGNATURE George W. Stover, M.D. (Deceased's name) | 22b. ADDRESS 600 N. Union | 22c. DATE SIGNED 1-9-59 |
|---|-------------------------------------|-----------------------------------|

| | | | |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Jan. 10, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri |
|--|-----------------------------------|---|---|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR Math Hermann & Son, Inc., 2161 E. Fair ADDRESS | 25. DATE RECD. BY LOCAL REG. JAN 9 '59 | 26. REGISTRAR'S SIGNATURE J. Carl Smith MD M.D.B. |
|--|--|--|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Hugh G. Burns*
Licensed Embalmer No. *4202*
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.