

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 7 1960

STATE FILE NUMBER
60-008810

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2, 2031**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 51 days	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge		c. CITY OR TOWN Collinsville	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) No. 9 Fieldcrest Lane	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CLAUDE Middle HAGER Last RYAN			4. DATE OF DEATH Month 2 Day 22 Year 1960			
5. SEX Male	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 8-27-12	9. AGE (last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lunotype Machinist		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (City and state or country) Carlyle, Ill.		
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Harry M. Ryan		13b. MOTHER'S MAIDEN NAME Harriet Baker		
14. NAME OF HUSBAND OR WIFE Verna L. Carter Ryan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. 11				
16. SOCIAL SECURITY NO. 550-03-0423		17. INFORMANT No. 9 Fieldcrest Verna L. Ryan, Collinsville, Ill.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, metastatic to brain		INTERVAL BETWEEN ONSET AND DEATH 7 mos
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.	Month, Day, Year _____		
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 **August 1950** to **Feb 22, 1960** and last saw ^{him} alive on **Feb 21, 1960**
Death occurred at **2:18 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph L. Lunnigan M.D.	(Degree or title)	22b. ADDRESS 634 N Grand	22c. DATE SIGNED FEB 23 1960
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2/22/60	23c. NAME OF CEMETERY OR CREMATORY Carlyle	23d. LOCATION (City, town, or county) (State) Carlyle Illinois
24. FUNERAL DIRECTOR Hubert H. [Signature]	ADDRESS Collinsville, Ill.	25. DATE RECD. BY LOCAL REG. FEB 23 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

mjb

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by W. J. Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert A. Kusch

Licensed Embalmer No. 2803

P. O. Address Collinsville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.