

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS: SEP 21 1960

-60-036517

INDEXED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8729 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>Life</u>	
c. FULL NAME OF DECEASED (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Ann's Home</u>		d. STREET ADDRESS (If outside, give location) <u>5660 Kingsbury Blvd.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>C.</u> Last <u>Ryan</u>			4. DATE OF DEATH Month <u>September</u> Day <u>4th</u> , Year <u>1960</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Edward Cronin</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Murphy</u>		14. NAME OF HUSBAND OR WIFE <u>Thomas L. Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Charles L. Hudson, 113 Hawthorne Ests.,</u>	

18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u>
Conditions, if any, which gave rise above cause, stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, generalized</u>			
DUE TO (c) <u>Diabetes mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260x</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 <u> </u> a.m. <u> </u> p.m. <u> </u>		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 <u>Jan 7-1954</u> to <u>Sept 9 1960</u> and last saw her <u>alive</u> on <u>7-21-60</u> Death occurred at <u>4:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Chas. L. Hudson</u>		22b. ADDRESS <u>1105 Central Clayton Mo</u>
22c. DATE SIGNED <u>9-6-60</u>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/7/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR <u>Arthur J. Donnelly</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 6 1960</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith, M.D.</u>
ADDRESS <u>3840 Lindell Blvd.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

110 S. Central
St.
S.M.
5 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Francis Hillion

Licensed Embalmer No. 356

P. O. Address 3840 Le

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