

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-043521

FILED VS DEC 14 1960

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11745** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 25 days	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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4475 West Pine HawthorneApts		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ISABELLE Middle RYCKMAN Last DODSON			4. DATE OF DEATH Month Dec. Day 6, Year 1960		
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/8/98	9. AGE (last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Private Duty	11. BIRTHPLACE (City and state or country) Emmons Co. N. Dakota	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME John Wesley Ryckman		13b. MOTHER'S MAIDEN NAME Margaret Ann Leitch		14. NAME OF HUSBAND OR WIFE None	
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. None	17. INFORMANT yes	Address St. Louis 8 Mrs. Ben C. Comfort 4475 West Pine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH 3-4 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Carcinoma of rectum					8-26-1956
DUE TO (c)					
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 checked="" type="checkbox"/> N: <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 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 Aug 22 1956 to present and last saw her him alive on Dec 5, 1960 Death occurred at 6A. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) William N Blalock, M.D.			22b. ADDRESS 114 N TAYLOR AVE.		22c. DATE SIGNED 12/6/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)
24. FUNERAL DIRECTOR ALEXANDER & SONS 6175 Delmar		ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 6 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Blalock
114 N Taylor
Je 3 8600

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 _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed jos. E Mc Cullough

Licensed Embalmer No. 2465

P. O. Address 6175 Lee

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.