LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29741

1. PLACE OF DEATH
County Franklin — Registration District No. 293 — File No.
Township — Primary Registration District No. 4177 — Registered No. 37
City Pacific (No. ..., ... St. ... Ward)

2. FULL NAME Agnes Ryan
(a) Residence. No. ... St., ... Ward. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U.S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF: Patrick Ryan

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 6 1860

7. AGE: Years 63 | Months 9 | Days 7 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN) ...
(STATE OR COUNTRY) Germany

PARENTS
10. NAME OF FATHER: Aug. Gerlach
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER: Do not know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY) Germany

14. INFORMANT: Wm Ryan
(Address) Pacific Mo.

15. FILED 10/15 1923 — A. J. Meyer, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 13 1923

17. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Oct. 12, 1923, that I last saw her alive on Oct 12, 1923, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Nervous prostration
G2A
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY): valvular lesion of heart (duration) 1 yrs. 1 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF ...
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) D. E. Williams, M. D
10/14, 1923 (Address) Pacific Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Catholic Cemetery Pacific Mo — DATE OF BURIAL: 10/15 1923

20. UNDERTAKER: Jno. A. Thiebes — ADDRESS: Pacific Mo

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos. .....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF .....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS