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

Do not use this space.

1. PLACE OF DEATH
County: Vernon — Registration District No. 875 — File No. 32546-B
Township: Washington — Primary Registration District No. 6162 — Registered No. 232
City: ~~[illegible]~~ (No. ..... St. ..... Ward)

2. FULL NAME: John P. Ryan
(a) Residence. No. State Hospital #3 St. ..... Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓
6. DATE OF BIRTH (MONTH, DAY AND YEAR): D.K. 1860
7. AGE: Years 67 — Months D.K. — Days D.K. — If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓
9. BIRTHPLACE (CITY OR TOWN): D.K.
(STATE OR COUNTRY): Mo

PARENTS
10. NAME OF FATHER: James Ryan
11. BIRTHPLACE OF FATHER (CITY OR TOWN): D.K.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Mary Murphy
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): D.K.
(STATE OR COUNTRY)

14. INFORMANT: Hospital Record
(Address) State Hospital #3
15. FILED 12-19 1927 E. R. King, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 2 1927
17. I HEREBY CERTIFY, That I attended deceased from April 17, 1927, to Oct 2, 1927, that I last saw ~~h.~~ alive on Oct. 2, 1927, and that death occurred, on the date stated above, at 1:35 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
Manic Depression
3 | LSA 84 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY): Pulmonary T.B.
(duration) D.K. yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? D.K.
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. J. Naples, M. D
, 19 (Address) State Hospital #3

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Joplin Mo. — DATE OF BURIAL: 10/9/27 19
20. UNDERTAKER: Turpin's Nevada Mo — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.