

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.

REC'D APR 17 1939

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

Do not use this space.

1. PLACE OF DEATH

County Jackson | Registration District No. 399
 Township How | Primary Registration District No. 1007
 City W. C., Mo. (No. General Hospital #2) | Registered No. 1056 (Ward)

2. FULL NAME

H. W. William Ryles
 (a) Residence, No. 560 P. C. 34th 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 <u>male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nancy Ryles</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>10-28-1872</u>		
7. AGE	YEARS <u>66</u>	MONTHS <u>4</u>
	DAYS <u>5</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Barber</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Arkansas</u>		
FATHER	13. NAME <u>Grainville Ryles</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nails</u>	
MOTHER	15. MAIDEN NAME <u>Deceased</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>	
17. INFORMANT <u>Record Clerk</u> (ADDRESS) <u>Gen. Hosp. #2</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Beulah Cem.</u> DATE <u>3/7/39</u>		
19. UNDERTAKER <u>West Appletown Me. Ins.</u> (ADDRESS) <u>1905 Pine St.</u>		
20. FILED <u>Mon 8, 1939 11. m.</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-5 .1939
 22. I HEREBY CERTIFY, That I attended deceased from 3-3 1939 to 3-5 1939
 I last saw him alive on 3-5 1939 Death is said to have occurred on the date stated above, at 6:00 m. P. M.
 The principal cause of death and related causes of importance were as follows:

Bilateral Pulmonary Tuberculosis
 Other contributory causes of importance:

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. O. Brown M. D.
 (Address) General Hospital #2

E. W. West
2710