

Registration District No. 379

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 27 days  
In this community 18 Yrs.  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2123 East 14th St.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month March day 16th  
year 1941 hour 6:00 A.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 2-17-41 19 to 3-16-41 19  
that I last saw him alive on 3-16-41 19  
and that death occurred on the date and hour stated above.  
Immediate cause of death Ascites  
Duration \_\_\_\_\_

Due to Cirrhosis of liver  
Due to Chronic pulmonary edema and congestion  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy See above

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(Specify means of injury) \_\_\_\_\_  
23. Signature Ruey R. Stone (M. D. or other)  
Address Med. Dir. K.C. Gen. Hospital 3rd fl.

PHYSICIAN  
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mike Ryan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 70

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Wid.  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 18 years  
7. Birth date of deceased Sept 15, 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Illinois (City, town or county) (State or foreign country)

10. Usual occupation Retired night watchman

11. Industry or business Printing Company

12. Name Michael C. Ryan

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Margaret Romaha

15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant John Ryan

(b) Address Frankfort, Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/18/41 (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Hosp. Indep.

18. (a) Signature of funeral director W. G. Carson  
(b) Address Indep. Indings, Indep.

19. (a) Nov 17, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed:

*H. Lloyd C. Barsa*

Licensed Embalmer No. *4199*

P. O. Address *Independence*

**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 this body is not embalmed, fact should be so stated above.**