DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10321

Primary Registration District No. 100

Registrar's No. 30

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

1. PLACE OF DEATH:

(a) County: Buchanan,

(b) City or town: Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1514 South 33rd. Street,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1

In this community: 76 yrs. 9 mos. 13 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri, (b) County: Buchanan, 011

(c) City or town: Saint Joseph, 1
(If outside city or town limits, write "RURAL")

(d) Street No.: 1514 South 33rd. Street 7
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME: Thomas J. Ryan,

3. (b) If veteran, name war: None,

3. (c) Social Security No.: None,

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married, 1

6. (b) Name of husband or wife: Gertrude Ryan,

6. (c) Age of husband or wife if alive: 62 years

7. Birth date of deceased: June 10th, 1865
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
76	9	13	hr. min.

9. Birthplace: Saint Joseph, (City, town, or county) Missouri, (State or foreign country)

10. Usual occupation: Printer,

11. Industry or business: Nelson-Hanne Printing Co.

FATHER
12. Name: Thomas Ryan,
13. Birthplace: Unknown, (City, town, or county) Ireland, (State or foreign country)

MOTHER
14. Maiden name: Unknown,
15. Birthplace: Unknown, (City, town, or county) Ireland, (State or foreign country)

16. (a) Informant: Mrs. Thomas J. Ryan
(b) Address: 1514 South 33rd. Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/25/42 (Month) (Day) (Year)

(c) Place: burial or cremation: St.Jo.Mem.Park Cem.

18. (a) Signature of funeral director: Naylor-Pagel-Bowman Funeral Home

(b) Address: 319 So.10th. Street

19. (a) 3-25-42 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: March day: 23rd.
year: 1942 hour: 7:00 minute: P. M.

21. I hereby certify that I attended the deceased from 1-31-42, 19__, to 3-23-, 1942; that I last saw him alive on 3-22-, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Carcinomatosis	2 yrs.
Cachexia	6 mo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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

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)

While at work? (e) Means of injury: 0

23. Signature: M. R. Grimm (M. D. or coroner)

Address: Kirkpatrick Bldg. ST. JOSEPH Date signed: 3-24-42

(Licensed Embalmer's Statement on Reverse Side)

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 3.23

....., Registered Apprentice No.....

working under my personal supervision.

Signed Chas E. Zimmerfield

Licensed Embalmer No. 3069

P. O. Address 519 So. 10 St. St Joseph

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.

V. S. No. 2B
10M—8-21-41
I X29288

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STANDARD CERTIFICATE OF DEATH

State File No. 10321

Registration District No. 85 Primary Registration District No. 1001 Registrar's No.

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

1. PLACE OF DEATH: (a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: (a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Thomas J Ryan
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased June (Month) 16 (Day) 1866 (Year)
8. AGE: Years 76 Months 9 Days 13 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 23 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Carcinoma	
Due to Chronic Cachexia	
Due to Probably Gastric	
Due to as Primary	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 4 6 8
Of autopsy

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

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Geo E Summers (M. D. or other)
Address Date signed 5/5/42

SUPPLEMENTARY