S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 17 1942

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 23586

Registrar's No. 2969

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 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days (Specify whether

In this community 35 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 3 8

(d) Street No. 1238 Washington (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME JOHN RYAN

3. (b) If veteran, name war No

3. (c) Social Security No None

4. Sex M. 0

5. Color or race W.

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife ------

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

7. Birth date of deceased Oct. 29th, 1860 (Month) (Day) (Year)

8. AGE: Years 81 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Kansas 1 (City, town, or county) (State or foreign country)

10. Usual occupation Maintenance man

11. Industry or business K. C. Mo.

FATHER
12. Name Patrick Ryan
13. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Hill
15. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Eliza O'Brien

(b) Address Chapman, Ks.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-7-42 (Month) (Day) (Year)

(c) Place: burial or cremation Chapman, Ks.

18. (a) Signature of funeral director Geo. C. Carosn

(b) Address Indep. Mo.

19. (a) 8-6-42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5th year 1942 hour 1 minute 30 A. M. M.

21. I hereby certify that I attended the deceased from 8-1-42, 19__, to 8-5-42, 19__; that I last saw him alive on 8-5-42, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of femur, accidental fall on sidewalk; Senility

Due to 1860

Due to 39

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy None

Duration

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) See above 123

(b) Date of occurrence 8-1-42

(c) Where did injury occur? Not of record (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? About home (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Dwiery R. Hone (M. D. or other)

Address Med. Dir. K. C. Gen. Hospital Date signed 8-6-42

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(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.....

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

working under my personal supervision.

Signed Frank W. Rick

Licensed Embalmer No. 2249

P. O. Address Independence Mo.

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.