

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **36395**
Registrar's No. **4073**

Registration District No. **749**

Primary Registration District No. **1002**

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

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:
4217 Wabash
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **45 years**
years, months or days)

3. (a) PRINT FULL NAME **Mr. William H. Ryer**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or Race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Lulu P. Ryer**

6. (c) Age of husband or wife if alive **71** years

7. Birth date of deceased **March 11 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	7	21	_____ hr. _____ min.

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

10. Usual occupation **Retired**

11. Industry or business **Salesman**

12. Name **Henry Ryer**

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

14. Maiden name **Mary Henning**

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

16. (a) Informant **Mrs. Lulu P. Ryer**

(b) Address **4217 Wabash**

17. (a) **Burial** (b) Date thereof **11-4-1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Moriah Cemetery**

18. (a) Signature of funeral director **Freeman Mortuary**

(b) Address **Kansas City, Mo.**

19. (a) **11-3-42** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

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. **4217 Wabash**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **2**
year **1942** hour **11** minute **15 A.M.**

21. I hereby certify that I attended the deceased from _____, 19**42**, to _____, 19**42**,
that I last saw him alive on **October 15**, 19**42**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**

Due to **Coronary artery atherosclerosis. Cardiac decompensation.**

Due to **None**

Other conditions _____
(Include pregnancy within 3 months of death)

Duration **1 day**

10 yrs

8 yrs

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations **None**

Of autopsy **None**

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 _____

23. Signature **Graham** (M. D. or other) **J. M. D.**
Address **1220 Prof. Bldg. K.C. Mo.** Date signed **11-2-42**

1-1-51
Graduate Center
Office Bldg.
1152nd St.

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 *Clarence H. Chile*

Licensed Embalmer No. *3473*

P. O. Address *36 e 760*

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.