18567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 18 1948

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 251 Primary Registration District No. 3048 Registrar's No. 57

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

1. PLACE OF DEATH:

(a) County Nodaway

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

(c) Name of hospital or institution St Francis O (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 Days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Nodaway

(c) City or town Conception 14 (If outside city or town limits, write "RURAL")

(d) Street No. O (If rural, give location)

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

If yes, name country O

3. (a) PRINT FULL NAME MARY RYAN

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F 1

5. Color or race W.

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

6. (b) Name of husband or wife

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

7. Birth date of deceased 10 (Month) 1 (Day) 1870 (Year)

8. AGE: Years 72 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Plattsburg (City, town, or county) Mo O (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Rainey
13. Birthplace (City, town, or county) Ireland (State or foreign country)

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

16. (a) Informant James C. Lynch

(b) Address Conception Jct Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-43 (Month) (Day) (Year)

(c) Place: burial or cremation Conception Mo

18. (a) Signature of funeral director Proctor & Phillips

(b) Address Conception Jct Mo

19. (a) 4-15-43 (Date received local registrar) (b) Mary Coile (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 14 year 1943 hour 12:30 minute M.

21. I hereby certify that I attended the deceased from April 1, 1943, to Apr. 14, 1943 that I last saw her alive on Apr 13, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Aortic Insufficiency

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 92a
Of autopsy

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)

(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 O

23. Signature R. E. Simpson (M. D. or other)

Address Hanberry Mo Date signed 4-14-43

(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 Eaton Phillips

Licensed Embalmer No. 1895

P. O. Address Stanberry

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

E. No. 2B
—5-43
I X36930

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

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BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

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(a) County Nodaway

(b) City or town Maryville
(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
In this community
years, months or days)

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 Mary Ryan

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased Oct (Month) 1 (Day) 1870 (Year)

8. AGE: Years 72 Months 6 Days 13 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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) Mary Coile (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
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that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

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Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY