

S. No. 2
M-5-43
5-17-39
I X36871

FILED MAR 15 1944 2
Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 193

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: 1213 North 10th St. Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 weeks
In this community All his life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 238 West Nebraska Ave.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James A. Ryan

3. (b) If veteran, name war _____ 3. (c) Social Security No. 707-29-6338

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Widower

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

7. Birth date of deceased August 30 1872 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 5 25 hr. min.

9. Birthplace Buchanan County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Retired Fireman for the

11. Industry or business Burlington R. Road

12. Name Unknown Ryan

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

14. Maiden name Unknown Unknown

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

16. (a) Informant Rose Padula

(b) Address 624 North 8th Street

17. (c) Burial (b) Date thereof Febr. 28, 1944 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs. E.P. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 2-28-44 (b) Rose Henry (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25 year 1944 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Feb. 21 1944 to Feb. 25 1944 that I last saw him alive on Feb 21 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 4 day
Due to Atherosclerosis

Other conditions (Include pregnancy within 3 months of death) J3a1

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? _____

23. Signature J.R. Elliott (M. D. or other) While at work? (Specify type of place) (c) Means of injury _____
Address 701 1/2 Dr. Francis Dr. Date signed 2-28-44

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

MOTHER FATHER

APR 28 1944

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 *Mollie E. Sidenfaden*

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, 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.