

FILED NOV 12 1946

Registration District No. 149

Primary Registration District No. 1002

State File No. \_\_\_\_\_

Registrar's No. 4568

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: St. Joseph's Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether  
In this community 23 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3930 Harrison St.  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs Anna Ryan

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife John P. Ryan 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased: July 1, 1881  
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Patrick McCormally #  
13. Birthplace Ireland #  
(City or town or county) (State or foreign country)  
14. Maiden name Anna Ryan  
15. Birthplace Ireland #  
(City, town, or county) (State or foreign country)

16. (a) Informant John P. Ryan  
(b) Address 3930 Harrison St.

17. (a) Burial (b) Date thereof 10/30/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's  
18. (a) Signature of funeral director Thomas E. Quirk  
4316 Troost Ave.  
(b) Address \_\_\_\_\_

19. (a) 10-30-46 (b) Thalidine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28th.  
year 1946 hour 3.10 P. M. minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from Oct.  
24 1946, to 10-28 1946.  
that I last saw her alive on 10-28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Cerebral Hemorrhage

Due to Hypertensive Heart Disease  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: g3d PHYSICIAN \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 fall

23. Signature Leo M. Muller (M. D. or other) MD  
Address 3548 Indiana Date signed Oct-29

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

**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 *Thomas E. Jones*

Licensed Embalmer No. *3775*

P. O. Address *P. O. M.*

**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.**