

S. No. 2
OM-5-43
v. 5-17-39
I X36671

1311

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 5 1947
Registration District No.

Primary Registration District No. 1002

Registrar's No. 331

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: Research Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 hrs. 4 to 50''
Specify whether years, months or days

In this community 4 hrs. 50''

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay

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

(d) Street No. R # 8
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Baby Ryan

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year 1947 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Jan 13, 1947, to Jan 14, 1947, and that I last saw her alive on Jan 14, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration _____

4. Sex Female 5. Color or race w

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

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

7. Birth date of deceased: January 13, 1947
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 50'' min.

Due to Brain injury

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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

10. Usual occupation infant

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name Albert Wayne Ryan

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

14. Maiden name Beatrice Mae Tustan

15. Birthplace North Kansas City Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Albert Ryan

(b) Address North Kansas City, Mo

17. (a) Cremation (b) Date thereof 1-14-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Research Hosp

18. (a) Signature of funeral director _____

(b) Address P. O. no.

19. (a) 1-23-47 (b) Steraldine Holmes
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature R. K. ... (M. D. or other) _____
Address P. O. no. Date signed 1/17/47

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.....

Licensed Embalmer No.....

P. O. Address.....

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.