

FILED JUN 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Parks 16479
State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 506

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>St. Johns Hospital</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hosp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) _____ c. (Last) <u>Ryan</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 29, 1950</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Unknown</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>about 70</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>St. John Hosp.</u>	11. BIRTHPLACE (State or foreign country) <u>9</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>St. John Hosp. Springfield, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Aortic Aneurysm - non-syphilitic</u> (supp. report) <u>4-20-50</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 4, 1950</u> , to <u>May 29, 1950</u> , that I last saw the deceased alive on <u>May 29, 1950</u> , and that death occurred at <u>4 p.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>William Daul, M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>May 31, 1950</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>June 1, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>5-31-50</u> <u>W E Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H.H. Lohmeyer Springfield, Mo.</u>		

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

about him.

1596

APR 3 1964

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed *Walter E. James*

Licensed Embalmer No. *3898*

P. O. Address *George 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.