

FILED DEC 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40766

Registrar's No. 1255

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>1255</u>			
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> <i>D117</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u> <i>11/2 weeks</i>		c. LENGTH OF STAY (in this place) <u>2 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural: Washington. Twp.</u> <i>0110</i>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>R. R. #3, St. Joseph</u> <i>1</i>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Frank</u>			b. (Middle) <u>O.</u>		c. (Last) <u>Ryan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 5, 1951</u>		
5. SEX <u>male</u> <i>P</i>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 26, 1877</u>		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hour Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dairy farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Lafayette, Indiana</u> <i>1</i>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Thomas Ryan</u>			13b. MOTHER'S MAIDEN NAME <u>unk. Nelson</u>			14. NAME OF HUSBAND OR WIFE <u>Calista Fern Ryan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Frank Ryan, R.R.#3, St. Joseph, Mo.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebro-vascular accident</u> *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY* (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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>11/20</u> , 19 <u>51</u> , to <u>12/5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>12/5</u> , 19 <u>51</u> , and that death occurred at <u>11:15A</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.M.D.</u>			23b. ADDRESS <u>902 Edmund St. Joseph</u>			23c. DATE SIGNED <u>12/6/51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>12/7/1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Dec. 13, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casby</u> <i>446</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Heaton-Bowman Funeral Home</u> <u>St. Joseph, Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Brewster Dr. Carpenter

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 Embalmer No.

Signed *William Spalding*

Signed.....
Student Embalmer

Licensed Embalmer No. ~~37~~ 4535

P. O. Address *319 S 10th St Joseph*

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.