

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6259**
Registrar's No. **1147**

FILED MAR 13 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City c. LENGTH OF STAY (In this place) 60 YEARS

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City

d. FULL NAME OF HOSPITAL OR INSTITUTION 4433 SCARRITT Avenue

d. STREET ADDRESS (If rural, give location) 4433 SCARRITT Avenue **3088**

3. NAME OF DECEASED
a. (First) Agnes b. (Middle) TERS A c. (Last) Ryan

4. DATE OF DEATH (Month) (Day) (Year) Feb 21 1953

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH JAN. 30. 1882

9. AGE (In years last birthday) 71 10. IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) EMERALD KANSAS

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME THOMAS UNKNOWN

13b. MOTHER'S MAIDEN NAME UNKNOWN

14. NAME OF HUSBAND OR WIFE HERBERT WILSON RYAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. NONE

17. INFORMANT'S SIGNATURE OR NAME HERBERT L. RYAN ADDRESS 3829 E. 60th TERR KANSAS CITY, MO.

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) Acute coronary occlusion
ANTECEDENT CAUSES asthma
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) asthma
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
4200

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE GEO. C. Kealhofer (Degree or title) 3

23b. ADDRESS 4000 Broadway St

23c. DATE SIGNED 2-23-53

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE FEB 24 1953

24c. NAME OF CEMETERY OR CREMATORY MT. MORIAN CEMETERY

24d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI

DATE REC'D BY LOCAL REG. 2-24-53

REGISTRAR'S SIGNATURE Heraldine Smith

25. FUNERAL DIRECTOR'S SIGNATURE D. W. Thompson Sons

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

WS20

10910

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.....

..... Student Embalmer No.

.....
working under my personal supervision.

Student
Student Embalmer

Signed Charles H. Steckmy

Licensed Embalmer No. 4568

P. O. Address HC 1000

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.