

FILED JUN 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20091

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 164

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institutional residence before) a. STATE Missouri b. COUNTY St. Francois	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bonne Terre		c. CITY OR TOWN Farmington	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Bonne Terre Hospital		e. STREET ADDRESS (If rural, give location) 09410	

3. NAME OF DECEASED (Type or Print) a. (First) Amanda b. (Middle) Ryan c. (Last)	4. DATE OF DEATH (Month) June (Day) 12 (Year) 1954
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec 27 1878	9. AGE (In years) 75 (Months) 5 (Days) 15	10. HOURS IN 24 HRS. (Hour) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Charles Mudd	13b. MOTHER'S MAIDEN NAME Scholastic Bone	14. NAME OF HUSBAND OR WIFE James J. Ryan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Lansing Ryan ADDRESS Farmington Mo
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		3 years.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arterial Hypertension DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	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 June 11, 1954, to June 12, 1954, that I last saw the deceased alive on June 12, 1954, and that death occurred at 5 P. m., from the causes and on the date stated above.

23a. SIGNATURE D. Geo. L. Watkins M.D. (Degree or title)	23b. ADDRESS Farmington Mo	23c. DATE SIGNED 6-14-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE June 14 1954	24c. NAME OF CEMETERY OR CREMATORY OLD CALVARY	24d. LOCATION (City, town, or county) (State) Farmington, Mo.
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DATE REC'D BY LOCAL REG June 14 1954	REGISTRAR'S SIGNATURE Catherine Rudloff 289-0	25. FUNERAL DIRECTOR'S SIGNATURE COZEAN FUNERAL HOME ADDRESS Farmington, Mo.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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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.....
Signature of Student Embalmer

Signed.....

CH Cozear

Licensed Embalmer No. *4085*

P. O. Address *Farmington*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.