

FILED JAN 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3749**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **378** PRIMARY REG. DIST. NO. **6285** Registrar's No. **6**

1. PLACE OF DEATH a. COUNTY <b>WRIGHT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>MTN GROVE, RURAL</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>NORWOOD MO</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) <b>1140</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>ERNEST</b> b. (Middle) _____ c. (Last) <b>RYAN</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>JAN 9, 1955</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAR 21, 1910</b>	9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Common</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>NORWOOD, MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>Elmer RYAN</b>		13b. MOTHER'S MAIDEN NAME <b>JANE WOODS</b>		14. NAME OF HUSBAND OR WIFE <b>ANNA RYAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>WILLARD RYAN NORWOOD</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Fractured skull</b>		DUE TO (b) <b>Cerebral Haemorrhage</b>			Partially <b>1-9-55</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Open Shov. Wound of head, Max Penetrating Skull.</b>						

19a. DATE OF OPERATION <b>1-10-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Fractured Skull, Cerebral Haemorrhage</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Homicide</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public place, etc.) <b>Mountain Grove (Club)</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Mountain Grove Wright MO</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>1 9 1955 2 m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Hit on head with metal Pipe and Pick</b>	

22. I hereby certify that I attended the deceased from **Prophery** <sup>12:45</sup> ~~12:45~~ <sup>to</sup> ~~to~~ <sup>1:15</sup> ~~1:15~~ <sup>hours</sup> ~~hours~~ <sup>on</sup> ~~on~~ <sup>1-9-55</sup> ~~1-9-55~~ <sup>at</sup> ~~at~~ <sup>Mountain Grove, Mo.</sup> ~~Mountain Grove, Mo. <sup>and that death occurred at</sup> ~~and that death occurred at~~ <sup>Mountain Grove, Mo.</sup> ~~Mountain Grove, Mo. <sup>on the date stated above.</sup> ~~on the date stated above.~~ <sup>1-9-55</sup> ~~1-9-55~~~~~~

23a. SIGNATURE (Degree or title) <b>A. B. Ames M.D.</b>		23b. ADDRESS <b>Mountain Grove MO</b>		23c. DATE SIGNED <b>1-14-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>1-13-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>THOMAS</b>	
24d. LOCATION (City, town, or county) (State) <b>MTN GROVE MO.</b>		DATE REC'D BY LOCAL REG. <b>1-16-55</b>		REGISTRAR'S SIGNATURE <b>A. B. Ames</b> <b>348-0</b>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Seale - Winderly</b>					

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

40

0

**W.C.**

MAY 31 1955

RECEIVED JAN 25 1955  
WRIGHT CO. HEALTH DEPT.  
County File Number 155-12  
Date Filed 1-29-55

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 *Frank Seible* .....

Licensed Embalmer No. 411

P. O. Address *Inty Gro* .....

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.