

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 15 1955

State File No. 5061
761

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY OR TOWN <u>Independence</u>	
c. LENGTH OF STAY (in this place) <u>238</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <u>700.5</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>		STREET ADDRESS (If rural, give location) <u>1401 So. Logan Rd. Mo.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ollie</u> b. (Middle) <u>May</u> c. (Last) <u>RYAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2-17-55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>5-11-87</u>
9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Hardin Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>John Forshay</u>	13b. MOTHER'S MAIDEN NAME <u>Brown</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state year or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bernice Stetson</u> ADDRESS <u>H.C. 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute lymphocytic leukemia</u> ANTECEDENT CAUSES DUE TO (b) <u>Pneumonia, LUL.</u> <u>Atelectasis, pulmonary, b. lat.</u> DUE TO (c) <u>food - due to unusual phlegm - bronchi</u> 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 checked="" 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)	
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 <u>2-26</u> , 19 <u>55</u> , to <u>2-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>55</u> , and that death occurred at <u>2:28</u> p.m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Gustave Eisenman</u> (Degree or title) <u>MD.</u>		23b. ADDRESS <u>701 E 63rd Street</u>	23c. DATE SIGNED <u>2/17/55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2/19/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills</u>	24d. LOCATION (City, town, or county) (State) <u>H.C. Mo.</u>
DATE REC'D BY LOCAL REG. <u>2-18-55</u>	REGISTRAR'S SIGNATURE <u>Wendy Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Ryan</u> ADDRESS <u>H.C. Mo.</u>	

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

See page 2

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 *John B. Long*

Licensed Embalmer No. *293*

P. O. Address *H.C.S.*

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.