

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1415

STATE FILE NUMBER

325

FILED FEB 13 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

Health,  
Welfare  
Public  
Service

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

J. E. Castles

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, give TOWNSHIP only) Inside Limits OR TOWN KANSAS CITY Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION ST. MARY'S Hosp 33 YRS.		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> 3205 BROADWAY	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND D. RYAN		4. DATE OF DEATH Month Day Year 1 18 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1903
9. AGE (In years last birthday) 54		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER	10b. KIND OF BUSINESS OR INDUSTRY RAILROAD
11. BIRTHPLACE (City and state or country) MINONK, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DENNIS RYAN		14. MOTHER'S MAIDEN NAME MARGARET GIBBONS	
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. 709-10-8582	
17. INFORMANT RACHAEL RYAN		Address 3205 BROADWAY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) a late myocardial infarction DUE TO (b) atherosclerosis, aorta & coronary arteries? DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 20 min 4:01
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Dec 22-57 to Jan 18-58 and last saw him alive on Jan 17-58 Death occurred at 6:45 P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. E. Castles MD		22b. ADDRESS 1002 Argyle Bldg N6 N0	
22c. DATE SIGNED Jan 22-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 1-22-58	
23c. NAME OF CEMETERY OR CREMATORY CALVARY		23d. LOCATION (City, town, or county) K.C. (State) MO.	
24. FUNERAL DIRECTOR ADDRESS Melody-M-Gilley-Eyler LINWOOD MAIN		25. DATE RECD. BY LOCAL REG. 1-22-58	
26. REGISTRAR'S SIGNATURE neva Marshall			

(Licensed Embalmer's Statement on Reverse Side)

MR. RAYMOND RYAN

DR. CASTLES

Issue at St. Mary's Hospital

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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..... James W. Wair

Licensed Embalmer No. 46

P. O. Address K.E. 9

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.