

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035537**

**FILED VS OCT 22 1959**

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 167

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Clay</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u>	a. STATE <u>Mo</u>	b. COUNTY <u>Clay</u>
Length of stay in 1b <u>4 hrs</u>		c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>333 E. Park</u>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print)			<b>4. DATE OF DEATH</b>			
First <u>Brenda</u>	Middle <u>Low</u>	Last <u>Ryun</u>	Month <u>OCT</u>	Day <u>4</u>	Year <u>1959</u>	

<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-27-1959</u>	<b>9. AGE (last birthday)</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HR</b>
			Months <u>5</u>	Days	Hours	Min.

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <u>NORTH KANSAS CITY MO</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>
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<b>13a. FATHER'S NAME</b> <u>LAWRENCE RYUN</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Ruth ANN Jones</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>-</u>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	<b>17. INFORMANT</b> <u>RUTH ANN RYUN</u>	<b>Address</b> <u>333 E PARK</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>Circulatory Failure, Nonte</u>		<u>min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Intestinal Obstruction</u>	<u>1wk</u>
	DUE TO (c) <u>Fecal Impaction</u>	<u>1wk</u>

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b>
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b>	Hour	Month, Day, Year
	a.m. p.m.	

<b>20d. INJURY OCCURRED WHILE AT WORK?</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>COUNTY</b>	<b>STATE</b>
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**21.** I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 12:45 Am on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>Albert E. Upsher</u>	<b>22b. ADDRESS</b> <u>115 Kansas City, Mo</u>	<b>22c. DATE SIGNED</b> <u>10/4/59</u>
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<b>23a. BURIAL, CREMATION, OR REMOVAL (Specify)</b> <u>BURIAL</u>	<b>23b. DATE</b> <u>10-6-59</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>FAIRVIEW CEM</u>	<b>23d. LOCATION (City, town, or county)</b> <u>LIBERTY, MO</u>
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<b>24. FUNERAL DIRECTOR</b> <u>O.W. Newkome Jr M.C.</u>	<b>ADDRESS</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-5-59</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Marguerite Hudgens</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF.

**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

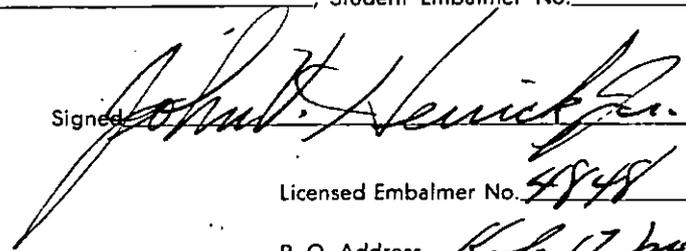
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4848

P. O. Address R. C. 17, 2nd

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.