

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

**-60-000662**

RECORDED VS JAN 18 1960

STATE FILE NUMBER

Registration District No. 61 Primary Registration District No. 4107 Registrar's No. 1

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cedar</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>El Dorado Springs</u> Length of stay in 1b c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>224 Hay St.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cedar</u> c. CITY OR TOWN <u>El Dorado Springs</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>224 Hay</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Elizabeth Jane Ryan</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>1-11-60</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>7-29-1869</u>	<b>9. AGE</b> (last birthday) <u>90</u>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> —		<b>11. BIRTHPLACE</b> (City and state or country) <u>Halt Co., Mo.</u>			
<b>13a. FATHER'S NAME</b> <u>James C. Tucker</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Mary S. Alcare</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Oliver Ryan</u>			
<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>Oliver Ryan</u> Address <u>224 Hay St. El Dorado Springs</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral encephalomalacia</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" 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.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>1958</u> to <u>1-8-60</u> and last saw <u>her</u> alive on <u>1-8-60</u> Death occurred at <u>8:30 p. m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> <u>Robert L. Magee, M.D.</u> (Degree or title)			<b>22b. ADDRESS</b> <u>119 West Spring Street El Dorado Springs, Missouri</u>		<b>22c. DATE SIGNED</b> <u>1-12-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>1-14-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hazel Dell Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Cedar Co., Mo.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Oliver Parathos - El Dorado Springs, Mo</u>			<b>25. DATE RECD. BY LOCAL REG.</b>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Ruth M. Graham</u> <u>By Hugh S. Allen</u>		

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

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Max W. Dickering*

Licensed Embalmer No. 4696

P. O. Address El Dorado

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