

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-60-035173**

FILED VS SEP 27 1960

146

Primary Registration District No.

3026

Registrar's No.

458

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Independence</b>		Length of stay in 1b <b>35 yrs.</b>		c. CITY OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Independence Sanitarium</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>206 1/2 North Main</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>R.</b> Last <b>Ryan</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>20,</b> Year <b>1960</b>									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10/17/1918</b>		9. AGE (last birthday) <b>41</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver - Southard</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cab Company</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>					
13a. FATHER'S NAME <b>Robert F. Ryan</b>				13b. MOTHER'S MAIDEN NAME <b>Ollie Forshay</b>				14. NAME OF HUSBAND OR WIFE <b>Julia 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. <b>496-10-0360</b>		17. INFORMANT Address <b>Bernice Stillwell 3414 E. 8th St.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Lower Nephron Nephrosis</b>													
DUE TO (c) <b>Injuries received when horse fell on him</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pulmonary fibrosis &amp; emphysema</b>								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					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input checked="" 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 a.m. p.m. <b>9/10/1960</b>		Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Loma Vista Stables</b>		20f. CITY, TOWN, OR LOCATION <b>Kansas City (Jackson) Mo.</b>		COUNTY		STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Hugh A. Owen</b>						22b. ADDRESS <b>152 Union Station</b>			22c. DATE SIGNED <b>9-21-60</b>				
23a. BURIAL OR CREMATION REMOVED (Specify) <b>burial</b>		23b. DATE <b>9/22/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Earp &amp; Sons Kansas City, Missouri</b>				25. DATE RECD. BY LOCAL REG. <b>9-22-60</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 10 1961

OCT 26 1960

NOV 1 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed William F. C.

Licensed Embalmer No. 472

P. O. Address H.C.

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