

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-033099

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4771

FILED OCT 11 1961

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>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Smithville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Lela</u> Middle <u>Opal</u> Last <u>Ryan</u>	4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1961</u>
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1894</u>	9. AGE (last birthday) <u>77 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>M. B. Cave</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Ann Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>John Jefferson Ryan</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Eva Tuller Smithville, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinomatosis generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>primary carcinoma of left kidney</u>	<u>unknown</u>
	DUE TO (c) _____	

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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 _____
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21. I attended the deceased from May 15, 1961 to Sept. 23 61 and last saw her/him alive on 9-23-61
Death occurred at 10:45P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Paul H. Johnston, M.D.</u> (Degree or title)	22b. ADDRESS <u>1110 Bryant Bldg., K. C. Mo.</u>	22c. DATE SIGNED <u>9-25-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>9-26-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I. O. O. F. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Mareamec, Oklahoma</u>
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24. FUNERAL DIRECTOR <u>Mc Comas Funeral Home</u>	ADDRESS <u>Smithville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-25-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF PAUL N. JOHNSON

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 _____ X

Licensed Embalmer No. _____

P. O. Address _____

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.