

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001993

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 002 Registrar's No. 247

STATE FILE NUMBER

FILED JAN 25 1962

AMENDED

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>			Length of stay in 1b <u>60 yrs.</u>		c. CITY OR TOWN <u>Kansas City</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>3621 Warwick</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3930 Harrison</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>P</u> Last <u>Ryan</u>				4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1962</u>				
5. SEX <u>Male</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>3-9-1878</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Special Officer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>First Nat'l Bank</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Patrick Ryan</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Scanlon</u>			14. NAME OF HUSBAND OR WIFE <u>Anna Ryan</u>		
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. [REDACTED]		17. INFORMANT Address <u>Mrs. Jack Francis 408 E. 73rd Terr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease c Failure and Myocardial Insufficiency</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis, Generalized with Cerebral Arteriosclerosis, Advanced</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) <u>Intercurrent Virus Infection c Bronchitis</u> 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						INTERVAL BETWEEN ONSET AND DEATH <u>10 YR</u> <u>RWKS</u> <u>10 YRS</u>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>None</u>						
20c. TIME OF INJURY Hour _____ p.m. _____ <u>None</u>	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.) <u>None</u>		20f. CITY, TOWN, OR LOCATION <u>None</u>		COUNTY _____	STATE _____			
21. I attended the deceased from <u>July 1947</u> to <u>1-14-1962</u> and last saw her/him alive on <u>1-14-62</u> Death occurred <u>9:20</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				22. ADDRESS <u>1019 Argyle Bldg.</u>				22c. DATE SIGNED <u>1/15/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>1-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>		
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>			ADDRESS <u>Woodland</u>		25. DATE RECD. BY LOCAL REG. <u>1-15-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

Mr. J. A. Crenshaw
Argyle Bldg.
Ba. 1-4060

11:30 to 3:00

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

Hal Stenberg

Licensed Embalmer No.

3408

P. O. Address

Indopi, Mo.

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.