

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039392

STATE FILE NUMBER

Registration District No. 88 Primary Registration District No. 5326 Registrar's No. 41

FILED OCT 29 1963

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEARAMEC TOWNSHIP</u>		Length of stay in lb <u>50 YRS.</u>	c. CITY OR TOWN <u>MEARAMEC TOWNSHIP</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 MILES E. STEELVILLE, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 MILES E. STEELVILLE, Mo.</u>
3. NAME OF DECEASED (Type or print) <u>FRED MARION RYAN</u>			4. DATE OF DEATH <u>OCT. 24 - 1963</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>1-8-1883</u>
9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>WASHINGTON Co., Mo. USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>ALEXANDER RYAN</u>	13b. MOTHER'S MAIDEN NAME <u>NANA FRANKLIN</u>
14. NAME OF HUSBAND OR WIFE <u>BELLE 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. <u>MARY RUSSELL 8654 W. KINGSBURY ST. LOUIS 24, Mo.</u>
17. INFORMANT <u>MARY RUSSELL 8654 W. KINGSBURY ST. LOUIS 24, Mo.</u>		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>Pulmonary occlusion</u>		DUE TO (b) <u>BRONCHIAL PNEUMONIA</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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"/>	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.	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
21. I attended the deceased from <u>8-7-1962</u> to <u>Oct. 21, 1963</u> and last saw ^{her} <u>him</u> alive on <u>Oct. 21, 1963</u> Death occurred at <u>EXACT TIME UNKNOWN</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George W. Johnson D.O.</u>		22b. ADDRESS <u>Steelville Mo.</u>	22c. DATE SIGNED <u>Oct. 25, 1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>10/27/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>STEELVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>STEELVILLE, Mo.</u>
24. FUNERAL DIRECTOR <u>HALBERT FUNERAL HOME - STEELVILLE, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT. 25, 1963</u>	26. REGISTRAR'S SIGNATURE <u>Harlan S. Beck</u>	

DO NOT WRITE ON THIS STUB

AMENDED

DATE AMENDED

VS 300 Rev. 4/59
1 022
2 0230
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4 0
5 2
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7 0
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9 9491X
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12 40-2
13 5-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

OCT 31 1963

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 Thomas S. Aldert

Licensed Embalmer No. 4332

P. O. Address STEEVILLE, 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.