

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Livingston Co.  
Township Chillicothe  
or  
Village  
or  
City Chillicothe (NO. 206 Ryan)

Registration District No. 508 File No. 23226  
Primary Registration District No. 3026 Registered No. 86  
St. 3rd Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Thomas A. Ryan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED Married WIDOWED OR DIVORCED  
(Write the word)

DATE OF DEATH July 20, 1914  
(Month) (Day) (Year)

DATE OF BIRTH July 28, 1839  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 31, 1910, to July 20, 1914, that I last saw him alive on July 20, 1914, and that death occurred, on the date stated above, at 11:30 p.m.

AGE 75 yrs. 11 mos. 21 ds. IF LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

The CAUSE OF DEATH\* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) "

Cerebral hemorrhage  
SVA  
97

BIRTHPLACE (City or town, State or foreign country) Livingston Co.

(Duration) 4 yrs. 1 mos. - ds.

NAME OF FATHER John Ryan

Contributory (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.

(Signed) W. M. Girardner M. D.

MAIDEN NAME OF MOTHER Susan Botte

July 21, 1914 (Address) Chillicothe, Mo.

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Lincoln Co. Mo.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? \_\_\_\_\_

(Informant) John A. Ryan  
(ADDRESS) Chillicothe Mo.

Former or usual residence \_\_\_\_\_

Filed July 22, 1914 J. C. Chilton REGISTRAR

PLACE OF BURIAL OR REMOVAL Edgewood Cemetery DATE OF BURIAL July 22, 1914

UNDERTAKER J. Mohr & Son ADDRESS Chillicothe Mo.

N. B.—Every item of information should be carefully supplied. An informant should be stated. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of ..... (name organ; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

PLACE OF DEATH  
*Livingston*  
County  
Township  
or  
Village  
or  
City  
*Chillicothe* (NO. \_\_\_\_\_) St.: \_\_\_\_\_ Ward)

Registration District No. *508* File No. \_\_\_\_\_  
Primary Registration District No. *3026* Registered No. *82*

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME *Thomas A Ryan*

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>M</i>	COLOR OR RACE <i>W</i>	SINGLE MARRIED WIDOWED OR DIVORCED <i>M</i> (Write the word)
DATE OF BIRTH <i>Satisfactory Information Supplied</i> _____, ____ (Day), ____ (Year)		
AGE <i>Satisfactory Information Supplied</i> ____ yrs. ____ mos. ____ ds. IF LESS than ____ day, ____ hrs. or ____ min.		
OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE (City or town, State or foreign country)		
PARENTS	NAME OF FATHER	
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	
	MAIDEN NAME OF MOTHER	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH  
*Satisfactory Information Supplied*  
*July 20*, 191*4*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_, that I last saw him \_\_\_\_\_, 191\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:  
*Cerebral Hemorrhage*  
*from Arterio Sclerosis*  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_  
(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) *J. M. A. [Signature]*  
*July 20, 1914* (Address) *Chillicothe*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

SUPPLEMENTARY INFORMATION SUPPLIED

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_  
Filed *X* \_\_\_\_\_ 191\_\_\_\_  
REGISTRAR *X*

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted  
If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL <i>Satisfactory Information Supplied</i>	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS <i>[Signature]</i>

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[Approved by U. S. Census and American Public Health  
Association]

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23226

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