

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

PLACE OF DEATH
County Sullivan ✓
Township Polk Registration District No. 452 File No. 15084
or Village _____ Primary Registration District No. 6120 Registered No. 6
or City Millersburg (NO. _____) St. _____ Ward _____
[If death occurred in a hospital or institution, give its NAME instead of street and number].

FULL NAME Mrs Elizabeth Ryan

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)

DATE OF BIRTH March 4, 1831
(Month) (Day) (Year)

AGE 84 yrs. 1 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer) 194B

BIRTHPLACE (City or town, State or foreign country) Virginia 82D

PARENTS
NAME OF FATHER Michael Hanegan
BIRTHPLACE OF FATHER (City or town, State or foreign country) Virginia 8 Apr 7 1915
MAIDEN NAME OF MOTHER Martha Temple
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. E. Ryan

(ADDRESS) Millers Mo

Filed 4-22 1915 E. Porter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Apr. 7th 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 29th 1915, to Apr 7th 1915
that I last saw him alive on Apr 6th, 1915

and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Result of Abraction of Penis on Apr 1st. Paralysis Stroke on Jan 29th. Post mortem to Apr 1st

(Duration) 2 mos. 3 ds.
Contributory Age, Paralysis
(SECONDARY) (Duration) yrs. mos. ds.

(Signed) J. P. Cooper M. D.
(Address) Millers Mo

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

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 Catholic Church Millers Mo DATE OF BURIAL Apr 9 1915

UNDERTAKER C. J. Schaefer ADDRESS Millers Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "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 septichaemia," "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.)

PLACE OF DEATH

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

County Greenway
 Township Rock
 or
 Village _____
 or
 City _____ (NO. _____ St.: _____ Ward)

Registration District No. 852 File No. _____
 Primary Registration District No. 6150 Registered No. 6

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

FULL NAME Elyzabeth Ryan

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED u
(# fills the word)

DATE OF DEATH Apr 7, 1915
(Month) (Day) (Year)

DATE OF BIRTH _____, _____, _____
(Month) (Day) (Year)

HEREBY CERTIFY, that I attended deceased from _____, 1915 to _____, 1915,
 that I last saw h. _____ alive on _____, 1915,
 and that death occurred on the date stated above, at _____.

AGE _____ yrs. _____ mos. _____ ds.
 If LESS than 1 day, _____ hrs. or _____ mins.

CAUSE OF DEATH* was as follows: accidental

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) _____

Caused from fall from 2nd floor apartment building. Disturb by tractor engine. Apr 6 - Paralytic stroke in the leg. 29 - Partial recovery. Apr 6 - 3 mos. 3 ds.

NAME OF FATHER _____

Contributory Apr Paris
(SECONDARY) (Duration) (Date) mos. ds.

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

(Signed) A.P. Cooper M. D.
Apr 7, 1915 (Address) Milam, Mo

MAIDEN NAME OF MOTHER _____

*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) _____

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death, _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(Informant) _____

Where was disease contracted? If not at place of death? _____

Former or usual residence _____

(ADDRESS) _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____, 1915

Filed 4/14, 1915

UNDERTAKER _____

ADDRESS _____

REGISTRAR _____

Original file, date _____

Apr 5, 1915 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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