

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Wear  
City Kansas City (No. Kansas City Genl Hosp)

Registration District No. 399  
Primary Registration District No. 1007

File No. 23864  
Registered No. 2990  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Ryan Infant

(a) Residence, No. General Hosp, St. \_\_\_\_\_, Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 26 - 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 12

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work label  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo

10. NAME OF FATHER Joseph Ryan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo

12. MAIDEN NAME OF MOTHER Julia Carter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) mo

14. INFORMANT Reverend Clerk (Address) K.C. Genl Hosp.

15. FILED 7/18 28 1928 M. M. Crowe REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-8 1928

I HEREBY CERTIFY That I attended deceased from 6-26, 1928, to 7-8, 1928, that I last saw her alive on 7-8, 1928, and that death occurred, on the date stated above, at 7:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Infectious diarrhea

17. CONTRIBUTORY (SECONDARY) 1130 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) P. B. Williams, M. D. 7-9, 1928 (Address) Sept 7. C. Gen. Hosp

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leeds DATE OF BURIAL 9-13-28

20. UNDERTAKER O. V. Mart ADDRESS \_\_\_\_\_

K. 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.

