

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

Do not use this space.

10644

1. PLACE OF DEATH

County Jackson
Township W. Ward
City Kansas City (No. Trinity Lutheran Hosp. St.)

Registration District No. 399

Primary Registration District No. 1002

File No. 1111
Registered No. 1111 (Ward)

2. FULL NAME

(a) Residence. No. 7 St. Smith Center, Kans. Ward. Smith Center, Kans.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 7 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND (OR) WIFE OF Mrs. Martha Rysen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 21, 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 | 11 | 16

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(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) Kansas

10. NAME OF FATHER Jacob Rysen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

12. MAIDEN NAME OF MOTHER Anna Frommer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT (Address) J. J. Rysen, 1400 S. 1st St., Kansas City, Mo.

15. FILED 27 19 29 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7-1929

17. I HEREBY CERTIFY, That I attended deceased from 3 12 1929 to 3-7-1929, and that I last saw him alive on 3-7-1929, and that death occurred, on the date stated above, at 1:15 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstruction bowels followed by embolism of pulmonary artery
1218
1170 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) 1218 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? Yes DATE 3-2-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) A. H. Hickley, M. D.
3-7, 19 29 (Address) 1025 Holladay

*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 Agenda, Kans. DATE OF BURIAL 3/8 1929

20. UNDERTAKER Freeman Mortuary ADDRESS 104 W. 42nd St.

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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2
26
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SECRET

SECRET

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Kan Primary Registration District No. _____ Registered No. 1149
 City K. C. Mo Trinity Lutheran Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. Smith Center Kan
 (Usual place of abode) (If nonresident give city or town and State)
 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 M 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
35 11 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 3/7 19 29 M. M. Brown REGISTRAR
Case

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7-1929
 17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw h. _____ alive _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Obstruction of bowels following
gastroenterotomy and
appendectomy
intestinal ulcer (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (PRIMARY) _____ (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 3/2/29
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address) _____

*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 _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

NO INK--THIS IS A PERMANENT

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

SUPPLEMENTARY

N. B. - CAUSE OF DEATH should be stated EXACTLY. If CAUSE should state. may be properly classified. Exact statement of OCCUPATION is very important.

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