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

Do not use this space.
40081

JAN 30 1931

1. PLACE OF DEATH
County: Marion
Township: Mason
City: Hannibal (No. 1701, Price ave St. Ward)

Registration District No. 547
Primary Registration District No. 3029

File No. 316
Registered No. 316

2. FULL NAME Margaret Ryan
(a) Residence. No. 1701 Price Ave St., Ward.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Ryan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 86			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): At Home.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Ireland

PARENTS
10. NAME OF FATHER Thomas Screen
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ✓ ✓ ✓
(STATE OR COUNTRY)

14. INFORMANT Mary Hollenbeck
(Address) Hannibal, Mo

15. FILED 12/11, 1930 C E Clemens
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-7-1930

17. I HEREBY CERTIFY, That I attended deceased from July-1, 1930, to Dec. 7, 1930, that I last saw h. alive on Nov 20, 1930, and that death occurred, on the date stated above, at 5 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion 1 21 M
A 2 HB
Duc
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) fractured, left hip
(duration) yrs. 6 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? physical examination
(Signed) H B Norton, M. D.
1930 (Address) Hannibal Mo

*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 St Marys Cemetery — DATE OF BURIAL 12/9/1930
20. UNDERTAKER James O'Donnell — ADDRESS Hannibal 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.

ad blue

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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.

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

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township — Primary Registration District No. 3029 — Registered No. 316

City Hannibal (No. ..... St. ..... Ward)

2. FULL NAME Margaret Ryan

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	W	Wid

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.

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)

PARENTS
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 12/11, 1930 C E Cousins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/7 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19.... that I last saw h..... alive on ....., 19...., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Fractured left hip

(duration) ..... yrs. 6 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? fell on floor while getting out of bed

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical findings

(Signed) H B Norton, M. D

2-12, 1931 (Address) Hannibal Mo

*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

SUPPLEMENTARY

5-40081