

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

Do not use this space.

14105

**1. PLACE OF DEATH**

County Jackson  
Township Ross  
City Kansas City (No. St. Mary's Hospital)

Registration District No. 399  
Primary Registration District No. 1007

File No. 1613  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 399 St. 10 Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>Wife of James C. Patrick</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 20 - 1869</u>		
7. AGE	YEARS <u>62</u>	MONTHS <u>7</u>
	DAYS <u>14</u>	If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Housewife</u> (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)  
Missouri

10. NAME OF FATHER  
Patrick Ryan

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

12. MAIDEN NAME OF MOTHER  
Laura Dr. Tatum

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

14. INFORMANT (Address)  
James C. Patrick (husband)  
139 South Spruce St.

15. FILED 4/6 1931 M. M. Corowe REGISTRAR  
Asor

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/4 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1931 to April 4 1931 that I last saw h. e. alive on April 4 1931 and that death occurred, on the date stated above, at 7:20 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Thrombus, peroneal artery  
of right leg. 59  
15A  
99A (duration) yrs. mos. ds. 18

CONTRIBUTORY (SECONDARY) diabetes and cry-  
suplasia of foot. (duration) yrs. mos. ds. 1

18. WHERE WAS DISEASE CONTRACTED ✓  
IF NOT AT PLACE OF DEATH. \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHO TEST CONFIRMED DIAGNOSIS General finding  
(Signed) Joseph M. Smith M.D.  
415 (Address) 925 Weyburn Rd.

\*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 BURIAL DATE OF BURIAL  
Cabany Cemetery 4/7 1931

20. UNDERTAKER ADDRESS  
Melby & Gilly Co. R.R. 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.

61

state blue-  
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*Joseph E. ...*

Applied. AGE sta  
sh

B—Every item  
for

**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.....

Registration District No. 399

File No.....

Township.....

Primary Registration District No. 1002

Registered No. 1613

City N. City (No. ....) St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... 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**

F

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

M

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

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

Aug 20 - 1869

**7. AGE**

YEARS

MONTHS

DAYS

IF LESS than 1 day, .... hrs. or .... min.

62 X 7 1 4

**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 4/6 31 M. M. Brown REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

Apr 4 19 31

**17.**

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

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

**CONTRIBUTORY (SECONDARY)**

**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)....., 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**

Every item of information should be carefully supplied. It 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

SUPPLEMENTARY

5-14105