

REC'D SEP 13 1936

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

27996

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Hew Primary Registration District No. 1097
(c) City K. C. Mo. (d) Street No. 121 W. 34th St Registered No. 8807
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Julia Ryan 517 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 6 1878
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 59 10 13
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation 1
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Castle Pennsylvania
13. NAME James Leahy
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown Ireland
15. MAIDEN NAME Margaret M. Mulloy
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland
17. INFORMANT (ADDRESS) Tom Ryan
121 W. 34th St. K. C. Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 8-27-38
19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. J. O'Donnell Co.
3756 Broadway
20. FILED Aug 21 1938 M. M. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 19 - 1938.

22. I HEREBY CERTIFY, That I attended deceased from March 1938, to August 19, 1938
I last saw her alive on Aug 19, 1938. Death is said to have occurred on the date stated above, at 12:45 A.M.
The principal cause of death and related causes of importance were as follows:

Bronchogenic Carcinoma of Lung
Date of onset 1937

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify _____
(Signed) Hubert W. Parker, M. D.
(Address) 736 Arroyo

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

FORM 1 X 14023

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.