

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.

DEC 18 1939 496
Registration District No. _____

Primary Registration District No. 3025

Registrar's No. 101

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

8. (a) PRINT FULL NAME James W Ryan 501

8. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex M 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Catherine Ryan 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 27 1866
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 4 If less than one day hr. _____ min. _____

9. Birthplace Syracuse NY
(City, town, or county) (State or foreign country)

10. Usual occupation Retired R.R. Conductor

11. Industry or business Ch. & N. R.R.

12. Name Jeremiah Ryan

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Tierney

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Joseph Adams

(b) Address Galesburg Mo

17. (a) Burial (b) Date thereof Nov 30
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brookfield Mo

18. (a) Signature of funeral director James D. Snowden

(b) Address Brookfield, Missouri 445

19. (a) Nov 2-39 (b) Joe D. Lusk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn
(c) City or town Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No. 515 E. Brookfield
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1939 hour 10:00 minute A M.

21. I hereby certify that I attended the deceased from 4/26, 1937, to 10/31, 1939; that I last saw him alive on 10/31, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Primary Occlusion Duration 2 hrs

Due to Primary stenosis - Hypertension

Due to Arteriosclerosis & other arterial changes 2 yrs

Other conditions _____

Major findings: Of operations none

Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) _____
While at work _____ (e) Means of injury _____

23. Signature James D. Snowden (M. D. or other) _____
Address Brookfield Mo Date signed 11/2/39

RECEIVED

District Health Officer No. 111

Case No. 1239-1657

Date filed DEC 8 1939

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 Homer Bowden

Licensed Embalmer No. 3295

P. O. Address Brookfield, N.H.

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.