

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 14 1943
Registration District No. 393

Primary Registration District No. 3074

No. 2
-5-42
5-17-39
X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Scott

(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Sikeston General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town Sikeston
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Tommy B. Ryan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Mar 27
1943 to Apr 2-4 1943
that I last saw him alive on Apr 1-4 1943
and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Ida Ryan

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April - 29 - 1894
(Month) (Day) (Year)

Immediate cause of death Hemorrhage
Gastric ulcer

8. AGE:

Years	Months	Days	If less than one day
<u>48</u>	<u>11</u>	<u>3</u>	_____ hr. _____ min.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

9. Birthplace Marion Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Brick Mason

11. Industry or business _____

MOTHER FATHER

12. Name Don't Know

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

14. Maiden name _____

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Wife

(b) Address Sikeston, Mo.

17. (a) Burial (b) Date thereof 4-3-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Orville Taylor

(b) Address Sikeston Mo

19. (a) 6-1-43 (b) Louis Legend
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____
(Specify type of place)

23. Signature Howard M. ... (M. D. or other) _____
Address Sikeston Mo Date signed 4-5-43

RECEIVED

District Health Office No. 2,

District File Number 643-822

Date Filed 6-10-43

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. 13474
P. O. Address Poplar Bluff

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, fact should be so stated above.