

No. 2
1-4-41
5-17-39
X2639

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20898

LED JUN 29 1943
Registration District No. 42

Primary Registration District No. 1001 1000

State File No. 610

Registrar's No. 6080

1. PLACE OF DEATH:

(a) County RICHANAN

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

(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 mo. 7 da.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 5331 Highland Ave.
(If rural, give location)

(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME CORNELIUS RYAN

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male 5. Color or race white

6. (a) Single widowed, married, divorced 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years (about) 75 Months Days If less than one day hr. min.

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

10. Usual occupation Janitor

11. Industry or business _____

MOTHER FATHER

12. Name Cornelius Ryan

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

14. Maiden name none

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

16. (a) Informant State Hospital Records

(b) Address _____

17. (a) Removal (b) Date thereof 6-1-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City Mo

18. (a) Signature of funeral director Frank A. Jabin

(b) Address Kansas City Mo.

19. (a) 6-1-43 (b) Rose A. Hergan
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
year 1943 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from May 27
1943 to May 30 1943
that I last saw him alive on May 30 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia Duration 6 days

Due to _____

Due to _____

Other conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Broncho pneumonia

Of operations Pulmonary tuberculosis

Of autopsy tuberculosis

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? _____ (a) Means of injury _____

23. Signature E. M. Boteler (M. D. or other) _____
Address St. Joseph Mo. Date signed 6/1/43

1235 Licensed Embalmer's Statement on Reverse Side

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

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..... *Charles M. Quirk*.....

Licensed Embalmer No. *2226*.....

P. O. Address..... *Kansas City, Mo*.....

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.