

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Prout Conv. Home, 4401 East 36th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mo. 28 days
(Specify whether
In this community 46 years
years, months or days)

3. (a) PRINT FULL NAME Mrs. Mabel A. Ryan
3. (b) If veteran, name war XX
3. (c) Social Security No. NO

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife William P. Ryan 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased September 28 1871
(Month) (Day) (Year)

8. AGE: Years 72 Months 3 Days 13
If less than one day hr. _____ min. _____

9. Birthplace Neosho County Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel Wood
13. Birthplace Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Helen Boomis
15. Birthplace 9
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. P. Ryan

(b) Address 955 West 42d St.

17. (a) Burial (b) Date thereof 1-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wm. Wagner
(b) Address Kansas City, Mo.

19. Jan 12 1944 (b) J E Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 955 West 42nd
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan. day 11th
year 1944 hour 4: minute 45 A.M.

21. I hereby certify that I attended the deceased from April 2 1943
19 Jan 11 19 44
that I last saw her alive on Jan 10 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Chronic nephritis & hypertension
Cerebral Hemorrhage
Due to _____
Hypertension, Atherosclerosis
Cardio-vascular disease
Other conditions _____
(Include pregnancy within 3 months of death)

Duration
3 weeks
Apr 1943
yo
PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations: _____
Of autopsy: _____

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)
(e) Means of injury _____
23. Signature Frank B. Brown (M. D. or other) 0
Address 928 Perry St., K.C.M. Date signed 1-11-44

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

3697

107. 112 3650

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 Cecil R. Matthes

Licensed Embalmer No. 3807

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.