

FILED JAN 25 1944

Registration District No. **128**

Primary Registration District No. **2000**

Registrar's No. **52**

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield** **MO.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**718 WOODLAWN 1**  
(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)

3. (a) PRINT FULL NAME **MINNIE RYAN.**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOW**

6. (b) Name of husband or wife **unk.** 6. (c) Age of husband or wife if alive **Dec. 23 - 1857** years (Month) (Day) (Year)

8. AGE: Years **86** Months **8** Days **20** If less than one day hr. min.

9. Birthplace **unk.** **Holland 4** (City, town, or county) (State or foreign country)

10. Usual occupation **House wife** **At Home**

11. Industry or business

12. Name **Henry Jansen**

13. Birthplace **unk.** **Holland 4** (City, town, or county) (State or foreign country)

14. Maiden name **unk.** **Unknown** (City, town, or county) (State or foreign country)

15. Birthplace **unk.** **Unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **James H. Ryan**

(b) Address **SPRINGFIELD** **MO.**

17. (a) **Burial** (b) Date thereof **Jan 16 1944** (Month) (Day) (Year)

(c) Place: burial or cremation **Robberson**

18. (a) Signature of funeral director **J. W. K. Lingner Co.**

(b) Address **SPRINGFIELD** **MO.**

19. (a) **1-13-44** (b) **Dr. W. E. Handley** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO.** (b) County **GREENE** **39**  
(c) City or town **SPRINGFIELD** **2**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **718 Woodlawn** **6**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **13** year **1944** hour **3** minute **50** A. M.

21. I hereby certify that I attended the deceased from **Jan 12 1944** to **Jan 12 1944** that I last saw h. **w** alive on **Jan 12 1944** and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **1 wk**

Due to **107**

Due to

Other conditions **Heart had been very poor** (include pregnancy within 8 months of death)

Major findings: **for past 18 yrs** Of operations

Of autopsy

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

(a) Accident, suicide, or homicide (specify) **No**

(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 **0**

23. Signature **Robert J. Williams** (M.D. or other) Address **Springfield mo** Date signed **1-13-44**

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

**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.....

*J. Klingner*

Licensed Embalmer No.....

3358

P. O. Address.....

*Springfield, 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.**