

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 15572

FILED APR 18 1944

Registration District No. 293

Primary Registration District No. 6003

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Polk  
(b) City or town Oakwood  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rt. 4 Rural  
(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

Dennis 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 Widowed  
6. (b) Name of husband or wife Mollie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec. 1 - 1866  
(Month) (Day) (Year)

8. AGE: Years 77 Months 1 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Polk Co. MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Michael Ryan  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Elizabeth DeLaney  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Ryan L. \_\_\_\_\_  
(b) Address Rt 4 Hannibal MO

17. (a) Burial (b) Date thereof Jan. 22 - 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem

18. (a) Signature of funeral director James O'Connor

(b) Address Hannibal MO

19. (a) 1-29-44 (b) R. B. Borker  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Polk  
(c) City or town Oakwood  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20  
year 1944 hour \_\_\_\_\_ minute 72 M.

21. I hereby certify that I attended the deceased from 19. 34 19 Jan 20 19 44  
that I last saw him alive on Jan 19 19 44  
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction  
Due to Arterio sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) no

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 W. H. Winkler (M. D. or other) \_\_\_\_\_  
Address Hannibal MO Date signed 1-28-44

RECEIVED

District Health Officer No. 10

District File Number 4-44-842

Date Filed APR 18 1944

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

*Michael J. O'Rourke*

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.**