S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 22 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30559

State File No.

Registration District No. 42 Primary Registration District No. 1005134 Registrar's No. 915

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph Rural War Ring
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Route # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 8 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. Rural R. # 1
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Annie Elizabeth Ryan
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Dennis Ryan
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 25 (Day) 1871 (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	5	12	hr. min.

9. Birthplace Buchanan (City, town, or county) County (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name Capt. Randall
13. Birthplace UnKnown (City, town, or county) Unknown (State or foreign country)
MOTHER
14. Maiden name Elizabeth Yates
15. Birthplace Unknown (City, town, or county) Missouri (State or foreign country)
16. (a) Informant T.R. Ryan
(b) Address 3908 Faraon St
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Axtell, Kansas
18. (a) Signature of funeral director Herman Wm Siderfaden
(b) Address 1802 Union St. St. Joseph, Mo.
19. (a) 9/9/44 (Date received local registrar) (b) Helen L. Fickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 7
year 1944 hour 9 minute 15 P.M.
21. I hereby certify that I attended the deceased from March 1943, 19, to Sept. 7, 1944
that I last saw her alive on Sept 5, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death rt. hemiglegia — progressive
Due to chronic myocarditis Hypertension 5 yrs.
rt. hemiglegia (cerebral hemorrhage) 1 wk.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration 1 wk.

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

93d

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? (e) Means of injury
23. Signature Wm. Toothaker M.D. (M.D. or other)
Address Kirkpatrick Bldg Date signed 9/8/44

1577

(Licensed Embalmer's Statement on Reverse Side)

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address St Joseph 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.