No. 2
—2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1945

Registration District No. 799

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1602

State File No. 1413

Registrar's No. 496

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Joseph Hospital. 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Mo. 26 Days (Specify whether years, months or days)

In this community 58 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Mo. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2410 East 29th, Street. 1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 11

3. (a) PRINT FULL NAME Joseph D. RYAN.

3. (b) If veteran, name war No

3. (c) Social Security No. N O N E

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Pearl Ryan

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased February 16, 1886.
(Month) (Day) (Year)

8. AGE: Years 58 | Months 11 | Days 13 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Fireman

11. Industry or business Kansas City Fire Dept.

FATHER
12. Name John W. RYAN
13. Birthplace Chicago, (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Mary Ellen Sherin
15. Birthplace Liberty, (City, town, or county) Missouri. 0 (State or foreign country)

16. (a) Informant Mrs. P.S.Ryan
(b) Address 5245 BrookwoodRoad, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/45. (Month) (Day) (Year)
(c) Place: burial or cremation St. Mays Cemetery

18. (a) Signature of funeral director Mellody-McGilley
(b) Address Kansas City Mo.

19. (a) 1-31-45 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 29th
year 1945 hour ___ minute ___ M.

21. I hereby certify that I attended the deceased from Jan 29, 1945, to Jan 29, 1945, that I last saw him alive on Jan 28, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion — Duration 3 hrs.

Due to Myocardosis. Hypertension 2 yrs

Due to

Other conditions (Include pregnancy within 3 months of death) 94a

Major findings:
Of operations

Of autopsy

PHYSICIAN — 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? (e) Means of injury

23. Signature William M Kirk (M. D. or other)

Address 612 Professional Bldg Date signed 1/29/45

(Licensed Embalmer's Statement on Reverse Side)

Dr. Korth
Prof. Bldg.

6 #2

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.....

Licensed Embalmer No.....2999

P. O. Address.....KC

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.