

3617

FILED FEB 24 1945

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 134

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
501 So. 8th. St. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community 44 Years

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. 501 So. 8th. St.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Theresa 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, Widowed
 6. (b) Name of husband or wife Thomas J.
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 12 1872
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>6</u>	<u>22</u>	hr. _____ min.

9. Birthplace Baraboo Wisconsin
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Michael Salmon
 13. Birthplace Queens County Ireland
(City, town, or county) (State or foreign country)
 14. Maiden name Brigid Timlin
 15. Birthplace County Mayo Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Geo. A. Bliley
 (b) Address 1328 So. 24th. St.

17. (a) Burial (b) Date thereof Feb. 6, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Norman Schubert
 (b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 2-6-45 (b) Delia J. Giesler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 4
 year 1945 hour 12 minute 00 (Noon)

21. I hereby certify that I attended the deceased from January 6, 1945 to February 4, 1945;
 that I last saw her alive on February 4, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocardial insufficiency
 Due to Chronic Hypertension

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 93.2
 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)
 (a) Means of injury 0
 23. Signature Gustav J. Han (M. D. or other) MD
 Address Kirkpatrick Bldg. St. Joseph, Mo. Date signed 2/6/45

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

MOTHER FATHER

Duration

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

Keith Collier

Licensed Embalmer No. *3632*

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.