

S. No. 2
-12-45
5-17-39
PI X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33753

State File No. _____

Registrar's No. **4167**

FILED OCT 16 1946
Registration District No. 149

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
In front 10 East 39th Street 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX
46 years (Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **46**

(c) City or town Kansas City **2**
(If outside city or town limits, write "RURAL")

(d) Street No. 5637 Rockhill Road **5**
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME C. CLIFFORD RYAN

3. (b) If veteran, name war No

3. (c) Social Security No. 486-07-6568

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 1
year 1946 hour 5:00 minute _____ P. M.

4. Sex Ma 5. Color or race Wh

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

6. (b) Name of husband or wife Maribah Ryan

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased November 5 1896
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

| | | | |
|----|----|----|----------|
| 49 | 10 | 26 | hr. min. |
|----|----|----|----------|

Immediate cause of death Coronary sclerosis

Due to arteriosclerosis

Due to _____

9. Birthplace Roodhouse Illinois
(City, town, or county) (State or foreign country)

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

10. Usual occupation Traffic Manager

11. Industry or business Continental Grain Co.

Major findings: Of operations _____

Of autopsy Histology & Biopsy

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

MOTHER FATHER

12. Name Wm. P. Ryan

13. Birthplace Aley Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Mabel A. Wood

15. Birthplace Neosho County Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Wm. P. Ryan

(b) Address 3516 Main

17. (a) Burial (b) Date thereof 10-4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

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

(c) 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? _____

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. Wagner
Kansas City, Mo.

(b) Address _____

19. (a) 10-2-46 (b) Heraldine Holman
(Date received local registrar) (Registrar's signature)

(Specify type of place)

While at work? _____ (c) Means of injury Car

23. Signature [Signature] (M. D. or other) _____
Address 1424 [Address] Date signed 10-2-46

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..... *Cecil R. Matthes*
Licensed Embalmer No. *3807*
P. O. Address..... *Kansas city, 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.