

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **12823**

|   |  |  |  |   |   |  |   |
|---|--|--|--|---|---|--|---|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>150</u>  |  | PRIMARY REG. DIST. NO. <u>5572</u>  |   | Registrar's No. <u>72</u>  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> <u>118</u> |   |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Prairie Twnshp (Rural)</u>  |  | c. LENGTH OF STAY (in this place) <u>4 days</u>  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City 3</u>   |   |  |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jackson County Emergency Hospital</u>  |  |  |  | d. STREET ADDRESS (If rural, give location) <u>10313 S. 9th</u>   |   |  |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Fannie</u> b. (Middle) _____ c. (Last) <u>Ryan</u>   |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>April 9, 1949</u> |   |   |  |   |
| 5. SEX <u>female</u>  |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 9</u>   |   | 8. DATE OF BIRTH <u>July 2, 1868</u>                             |   |
| 9. AGE (In years last birthday) <u>80</u>   |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 4 HRS. Hours _____ Min. _____  |   |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>     |   | 11. BIRTHPLACE (State or foreign country) <u>unknown, Ills. /</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>America</u>                           |
| 13a. FATHER'S NAME <u>Harley Reed</u>   |  |  | 13b. MOTHER'S MAIDEN NAME <u>Sarah Green</u>               |   | 14. NAME OF HUSBAND OR WIFE <u>unknown, Ryan</u>                  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  | 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Fannie Ryan (pre-arranged)</u>  |   |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.   |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intertracheal fracture r. hip 3 days</u><br>ANTECEDENT CAUSES <u>Pernicious anemia yrs</u><br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |   |   |  | INTERVAL BETWEEN DEATH AND DEATH _____                                |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>ADDITIONAL SUPPLEMENTARY INFORMATION</u>   |  |   |   |  | #   |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>   |  | 21c. (CITY, TOWN, OR TOWNSHIP) <u>Independence</u>  |   | 21d. (COUNTY) <u>Jackson</u> (STATE) <u>Mo</u>                   |   |
| 21e. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>4-6-1949 8 a.m.</u>  |  | 21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21g. HOW DID INJURY OCCUR? <u>Fell off home</u>   |   |  |   |
| 22. I hereby certify that I attended the deceased from <u>6:45 p.m.</u> 19 <u>49</u> , to <u>9 p.m.</u> 19 <u>49</u> , that I last saw the deceased alive on <u>April 9, 1949</u> , and that death occurred at <u>4:45 p.m.</u> , from the causes and on the date stated above. |  |  |  |   |   |  |   |
| 23a. SIGNATURE (Degree of title) <u>Frank J. Johnson M.D.</u>   |  |  |  | 23b. ADDRESS <u>Independence, Mo</u>  |   | 23c. DATE SIGNED <u>10/9/49</u>                                  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>  |  | 24b. DATE <u>Apr. 12, 1949</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>   |   | 24d. LOCATION (City, town, or county) (State) <u>Mexico, Mo.</u> |   |
| DATE REC'D BY LOCAL REG. <u>4-11-49</u>   |  | REGISTRAR'S SIGNATURE <u>Ronald C. Eamshaw</u>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. Carson</u>  |   | ADDRESS <u>Independence, Mo.</u>                                 |   |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 48

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. 4123

P. O. Address Independence, 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.