

FILED DEC 3 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37489**
4910

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give city or town) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5433 Wornall Road		d. STREET ADDRESS (If rural, give location) 5433 Wornall Road	

3. NAME OF DECEASED (Type or Print) a. (First) William	b. (Middle) D.	c. (Last) RYAN, Sr.	4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1949
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH mar 2, 1861	9. AGE (In years last birthday) 88	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Arbitrator	10b. KIND OF BUSINESS OR INDUSTRY So. western Coal Opr.	11. BIRTHPLACE (State or foreign country) Joliet, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME James Ryan	13b. MOTHER'S MAIDEN NAME Anna Roach	14. NAME OF HUSBAND OR WIFE Alice T. Ryan
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Wm. S. Ryan, Jr.	ADDRESS 5037 Forest, K.C., Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 30 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Achalasia			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4-2-2	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 1947, to 11-17, 1949, that I last saw the deceased alive on 11-16, 1949, and that death occurred at 3 A. m., from the causes and on the date stated above.

23a. SIGNATURE Marvin B. Ketrion (Degree or title)	23b. ADDRESS 1103 Grand	23c. DATE SIGNED 11-18-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11-19-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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DATE REC'D BY LOCAL REG. 11-18-49	REGISTRAR'S SIGNATURE S. Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Mellody-McGilley-Eylar	ADDRESS Kansas City, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0157 11.0.11.
K2. Keston
F. J. Kelly

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 Glen E. Hack.....

Licensed Embalmer No. 4063.....

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.