

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

13056

State File No. _____

FILED APR 7 1953

Registrar's No. **70**

BIRTH NO. _____ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225**

1. PLACE OF DEATH a. COUNTY Union		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Cass	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Wash. Township		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Harrisonville	
c. LENGTH OF STAY (In this place) 9-3-0		d. STREET ADDRESS (If rural, give location) 1005 W. Mechanic	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 3.			

3. NAME OF DECEASED (Type or Print) a. (First) Hazel. b. (Middle) Nadene c. (Last) Ryan.			4. DATE OF DEATH (Month) (Day) (Year) 3 31 53		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 4-18-1923		9. AGE (In years last birthday) 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and State or Foreign Country) Cass County Mo.		12. CITIZEN OF WHAT COUNTRY? USA.

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Maudie Spawr	13c. NAME OF HUSBAND OR WIFE Never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Records State Hosp # 3 Nevada Mo.	ADDRESS Nevada 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia unspecified		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial Heart Failure DUE TO (c) 493X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental Deficiency			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1952, to March 31, 1953 that I last saw the deceased alive on March 30 1953, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE George Wheeler Wilson MD (Degree or title)	23b. ADDRESS State Hospital # 3.	23c. DATE SIGNED 3-31-1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-31-53	24c. NAME OF CEMETERY OR CREMATORY Cass County	24d. LOCATION (City, town, or county) (State) Hunterville Ark.
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DATE REC'D BY LOCAL REG. 4-3-53	REGISTRAR'S SIGNATURE Anna E. Ferry	25. FUNERAL DIRECTOR'S SIGNATURE Bracewell and Co.	ADDRESS Hunterville, Ark.
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(Licensed Embalmer's Statement on Reverse Side)

No. 300
10.48

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

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 Marsh, Eickinger

Licensed Embalmer No. 2656

P. O. Address Newark, 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.