

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

19103

State File No.

FILED JUN 23 1955

No. 300
10.48

BIRTH NO. _____		REG. DIST. NO. <u>150</u>		PRIMARY REG. DIST. NO. <u>4240</u>		Registrar's No. <u>110</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Jackson		a. STATE Mo		b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Blue Springs)		c. LENGTH OF STAY in this place 10 yrs		c. CITY OR TOWN Blue Springs		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION City South 8th Street				e. STREET ADDRESS (If rural, give location) City South 8th street			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) John	b. (Middle) W	c. (Last) Ryan	(Month) June	(Day) 14	(Year) 1955		
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married (Specify)	8. DATE OF BIRTH Nov 15 1872		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (City and State or Foreign Country) Grain Valley Mo.		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME John Ryan		13b. MOTHER'S MAIDEN NAME Lucindia Warren		14. NAME OF HUSBAND OR WIFE Ida B Ryan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Ida B Ryan Blue Springs Mo			
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	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>				<u>36h</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterial sclerotic heart disease</u> DUE TO (c) <u>4200</u>				<u>10 yr +</u>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-22</u>, 19<u>49</u> to <u>June 17</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6-13</u>, 19<u>55</u>, and that death occurred at <u>6 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Merrill R. Bay M.D.</u>				23b. ADDRESS <u>Blue Springs, Mo.</u>		23c. DATE SIGNED <u>6-15-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 16 1955	24c. NAME OF CEMETERY OR CREMATORY Blue Springs		24d. LOCATION (City, town, or county) (State) Blue Springs Mo		
DATE REC'D BY LOCAL REG. 6-16-1955		REGISTRAR'S SIGNATURE <u>J. B. Langford</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Webb Funeral Home</u>		ADDRESS <u>Blue Springs Mo</u>	

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

(Licensed Embalmer's Statement on Reverse Side)

M

DEC 13 1957

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.....
Signature of Student Embalmer

Signed..... *R B Webb*

Licensed Embalmer No..... *23*

P. O. Address..... *Blum sp*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.