Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-035577
STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1109

REC'D OCT 27 1958

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Joseph — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 518 No.12th — Length of stay in Ib Life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St.Joseph — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 518 No.12th — Reside on Farm Yes [ ] No [X]

0117

3. NAME OF DECEASED (Type or print) First THOMAS Middle FRANCIS Last RYAN

4. DATE OF DEATH Month Oct. Day 15 Year 1958

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH June 8, 1878

9. AGE (In years last birthday) 80 — 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) Ret(12)Hotel Operator

10b. KIND OF BUSINESS OR INDUSTRY Hotel

11. BIRTHPLACE (City and state or country) St.Joseph,Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME John B. Ryan

13b. MOTHER'S MAIDEN NAME Rebbeca A Lewis

14. NAME OF HUSBAND OR WIFE Cornelia AnnnRyan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 491-10-4654

17. INFORMANT Address Mrs.T.F.Ryan,518 No. 12th, City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostalic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3-4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Being weak & bed fast
DUE TO (c) Arthritis 725X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1952, to 1958 and last saw her/him alive on 10:30 PM 10/14/58
Death occurred at 12:12 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] (Degree or title) MD.
22b. ADDRESS 423 Main
22c. DATE SIGNED 10/21/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Oct.17,1958
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State) St.Joseph, Missouri

24. FUNERAL DIRECTOR H.O. Sidenfaden & Son R.R.9.
ADDRESS St.Joseph,Mo
25. DATE RECD. BY LOCAL REG. Oct.22,1958
26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Dr. M. E. Riemer

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 ....Robert A. Gaple.....

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.