

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 6 1960

'59 044310

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6078

ENDED

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, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 50yrs		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PASEO NURSING HOME.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3300 PASEO		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ALTA M. RYAN				4. DATE OF DEATH Month Day Year DEC 16, 1959					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12 1882	9. AGE (last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) PARDEE, KANSAS		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME UNKNOWN			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE THOMAS RYAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address BILL RYAN 3300 PASEO K. C. MO.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral encephalomalacia, left parietal lobe</u> 3 days							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cerebral thrombosis</u> 3 days									
DUE TO (c) <u>cerebral arteriosclerosis</u> 10+ yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>hypertensive cardiovascular disease</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Dec. 13, 1959</u> to <u>Dec. 16, 1959</u> and last saw her ^{her} alive on <u>Dec. 13, 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Arthur Gene Petersen, M.D.</u>				22b. ADDRESS <u>411 Nichols Rd K.C. 12 Mo</u>			22c. DATE SIGNED <u>12-16-59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE DEC 18, 1959	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL		23d. LOCATION (City, town, or county) (State) KANSAS CITY MO.				
24. FUNERAL DIRECTOR ADDRESS D. W. NEWCOMER'S SONS K.C. MO.				25. DATE RECD. BY LOCAL REG. <u>12-17-59</u>		26. REGISTRAR'S SIGNATURE <u>new Marshall</u>			

DOCUMENT

BY AFFIDAVIT OF
Arthur Gene Petersen
MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert L. Savage

Licensed Embalmer No. 4812

P. O. Address Yonkers N.Y.

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.