

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048815

OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6643 STATE FILE NUMBER

FILED VS JAN 23 1967

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 lb. 1 month	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6033 SWOPE PARKWAY Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First VALLEE Middle E. Last RYAN			4. DATE OF DEATH Month DECEMBER Day 30 Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-12-95	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD WORK		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION	11. BIRTHPLACE (City and state or country) VANDALIA, ILLINOIS	12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME MARTIN RYAN		13b. MOTHER'S MAIDEN NAME PHILOMENA BRINGUARD		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 703 01 1308		17. INFORMANT CLIFFORD RYAN, K.C., MO. V.A. HOSPITAL OFFICIAL RECORDS, 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) generalized lymphadenopathy hepato-splenomegaly DUE TO (b) reticulum cell sarcoma DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 checked="" 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 _____ s.m. _____ p.m. _____	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. Attended the deceased from **December 19, 1960** to **December 30, 1960** and last saw him/her alive on **December 30, 1960**
Death occurred at **12:12 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. H. Owings (Degree or title) M.D.		22b. ADDRESS VA HOSPITAL KANSAS CITY, MO.		22c. DATE SIGNED 12-30-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 3, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR Muehlebach	ADDRESS 6800 Troost	25. DATE RECD. BY LOCAL REG. 1-2-61	26. REGISTRAR'S SIGNATURE Ruth Long	

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Clare V. Carr

Licensed Embalmer No. 4934
P. O. Address KC14, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.