

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004409

FILED VS FEB 7 1961

360

6225

13

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

AMENDED

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | |
|--|------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY VERNON | | | | 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 WASHINGTON TOWNSH. | | | Length of stay in 1b 1YR-11M-15D | | c. CITY OR TOWN KANSAS CITY, MO | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSP. #3 NEVADA, MO | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3930 HARRISON | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First NELLIS Middle LEONA Last RYAN | | | | 4. DATE OF DEATH Month FEBR. - Day 1 - Year 1961 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT. 16 1922 | 9. AGE (last birthday) 38 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY | | 10b. KIND OF BUSINESS OR INDUSTRY WOMENS CLOTHING | | 11. BIRTHPLACE (City and state or country) WENTZVILLE, MO | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME PHILIP RYAN | | | 13b. MOTHER'S MAIDEN NAME ANNIE SCANLAN | | | 14. NAME OF HUSBAND OR WIFE NEVADA HOSP. RECORDS STATE HOSP. MO | |
| 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. - | | 17. INFORMANT NEVADA HOSP. RECORDS STATE HOSP. 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) CORONARY OCCLUSION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS |
| DUE TO (b) GENERALIZED ARTERIO SCLEROSIS | | | | | | | YEARS |
| DUE TO (c) _____ | | | | | | | |
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 checked="" 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 FEBR. 17. 1959 , to FEBR. 1 - 61 and last saw her/him alive on FEBR. 1 - 1961 Death occurred at 1:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE W.C. Bradley MD (Degree or title) | | | | 22b. ADDRESS State Hospital #3 Nevada Mo | | 22c. DATE SIGNED 2-1-61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR Melody McMillen Egan ADDRESS 1800 E. Linwood R.C., MO | | 25. DATE RECD. BY LOCAL REG. Feb 4 - 1961 | | 26. REGISTRAR'S SIGNATURE Arma E. Ferry | | | |

(Licensed Embalmer's Statement on Reverse Side)

FEB 20 1961

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 James W. Wair

Licensed Embalmer No. 4650

P. O. Address K.C., Miss.

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.