

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-037174

4926

STATE FILE NUMBER

AMENDED

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

FILED OCT 19 1961

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived at time of death, if different from residence before admission) a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 3 months	c. CITY OR TOWN Kansas City, Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5331 Highland		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 810 Furberg Dr. Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) Thomas Ryan
 4. DATE OF DEATH Oct 2, 1961

5. SEX Male 6. COLOR OR RACE white 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH 9-10-1886 9. AGE (last birthday) 74 75 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) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (City and state or country) St. Charles Mo. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Phillip Ryan 13b. MOTHER'S MAIDEN NAME Ann Scanlon 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) No 16. SOCIAL SECURITY NO. 17. INFORMANT W. Haines, Slater, Mo. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Carcinoma of Thyrax
 DUE TO (b) _____
 DUE TO (c) _____
 CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 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 Month, Day, Year
 a.m. p.m.

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 June 20, 1961 to Oct 2, 1961 and last saw her alive on 10/1/61
 Death occurred at 2:40 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph A. Fogarty (Signature or title) 22b. ADDRESS 402 Northman Bldg. 69 Mo 22c. DATE SIGNED 10/3/61

23a. BURIAL, CREMATION, OR REMOVAL (Specify) 23b. DATE 10-3-61 23c. NAME OF CEMETERY OR CREMATORY - 23d. LOCATION (City, town, or county) Slater, Mo. (State)

24. FUNERAL DIRECTOR Haines Montuary, Slater, Mo. ADDRESS 25. DATE RECD. BY LOCAL REG. 10-4-61 26. REGISTRAR'S SIGNATURE Ruth Song

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF Joseph A. Fogarty, Medical Certification

NOV 21 1961
DEC 6 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 John R. Sidmo
Licensed Embalmer No. 4531
P. O. Address Jarvis City

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.