

No. 2
-13-40
-17-39
X23139

Registration District No. 104 Primary Registration District No. 3008 Registrar's No. 257

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(c) Name of hospital or institution: State Hosp #1 Fulton Mo 3
(d) Length of stay: In hospital or institution 33 days
In this community 33 days

3. (a) PRINT FULL NAME Robert Emmet Bryant
3. (b) If veteran, name war _____
3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Hettie Bryant 6. (c) Age of husband or wife if alive DE years
7. Birth date of deceased Mar 23 1873

8. AGE: Years Months Days If less than one day
67 67 6 11 hr. min.

9. Birthplace Cole County Mo

10. Usual occupation Farming

11. Industry or business _____
12. Name Robert Bryant
13. Birthplace Kentucky
14. Maiden name Lizzie Hudson
15. Birthplace Tennessee

16. (a) Informant State Hosp #1 Records
(b) Address Fulton Mo

17. (a) Buried (b) Date thereof 10/6/40
(c) Place: burial or cremation Centerville Cem

18. (a) Signature of funeral director Borulin Funeral Home
(b) Address Calamin 770

19. (a) Oct 4 1940 (b) R. N. Crewe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cole
(c) City or town Centerton
(d) Street No. _____
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Oct day 4th year 1940 hour 1 minute 05A M.

21. I hereby certify that I attended the deceased from Sept 1 1940 to Oct 4 1940
that I last saw him live on Oct 3rd and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis (cardio renal vascular)

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 121

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: no
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
While at work (e) Means of injury _____

23. Signature Chas. J. Wood (M. D. or other) MD
Address State Hosp #1 Date signed 10/4/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Earl R. Bowlin

Licensed Embalmer No. 2126

P. O. Address California 710

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34938

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Calloway
(b) City or town Fulton
(If outside city or town limits write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Robert Emmet Bryant

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w

(b) Name of husband or wife _____

(c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 67 Months 7 Days 1 If less than one day _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country) Missouri

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(b) Date thereof _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) April 1, 1991

(Date received local registrar)

(b) R. N. Crew

(Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Oct day 4
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings:

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature of Geo. F. Wood (M. D. or other) _____

Address Fulton Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

