WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Cole

Township: Marion

or Village:

or City: (NO. St.; Ward)

Registration District No. 211

File No. 15

Primary Registration District No. 5291

Registered No. 29826

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Vernon Sylvester Bryant

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	single

DATE OF BIRTH: Dec (Month) 22 (Day), 1914 (Year)

AGE: 4 yrs. 9 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Cole Co Mo

PARENTS

NAME OF FATHER: Emmett Bryant

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cole Co Mo

MAIDEN NAME OF MOTHER: Hattie Ann Alexander

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cole Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia Bryant

(ADDRESS) Centertown Mo

Filed 10-18-1919 Joe N Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 18 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 11, 1919, to Oct 18, 1919, that I last saw him alive on Oct 18, 1919, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) ___ yrs. ___ mos. 9 ds.

Contributory (SECONDARY) (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) B F Bagby M. D.

Oct 18, 1919 (Address) Centertown Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL:

DATE OF BURIAL: 10-19-1919

UNDERTAKER: Jack Bowlin

ADDRESS: Centertown Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County ____________

Township ____________ or Village ____________ or City ____________ (NO. ________ St.; ________ Ward)

Registration District No. ____________ File No. ____________

Primary Registration District No. ____________ Registered No. ____________

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME ____________

PERSONAL AND STATISTICAL PARTICULARS

SEX ________ COLOR OR RACE ________ SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word) ________

DATE OF BIRTH ________ (Month) ________ (Day), 1____ (Year)

AGE ________ yrs. ________ mos. ________ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ____________
(b) General nature of industry, business, or establishment in which employed (or employer) ____________

BIRTHPLACE (City or town, State or foreign country) ____________

PARENTS

NAME OF FATHER ____________

BIRTHPLACE OF FATHER (City or town, State or foreign country) ____________

MAIDEN NAME OF MOTHER ____________

BIRTHPLACE OF MOTHER (City or town, State or foreign country) ____________

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ____________

(ADDRESS) ____________

Filed ____________, 191____, ____________ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ____________ (Month) ________ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from ____________, 191____, to ____________, 191____, that I last saw h____ alive on ____________, 191____, and that death occurred, on the date stated above, at ________ m.

The CAUSE OF DEATH* was as follows:

____

____________ (Duration) ________ yrs. ________ mos. ________ ds.

Contributory (SECONDARY) ____________

____________ (Duration) ________ yrs. ________ mos. ________ ds.

(Signed) ____________ M. D.

____________, 191____ (Address) ____________

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____________

Former or usual residence ____________

PLACE OF BURIAL OR REMOVAL ____________ DATE OF BURIAL ____________, 191____

UNDERTAKER ____________ ADDRESS ____________