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

PLACE OF DEATH

County Callaway

Township Cedar

or

Village ✓

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 109 File No. 40716

Primary Registration District No. 5158 Registered No. 27

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

FULL NAME No name. Bryant

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Infant

DATE OF BIRTH: Dec (Month) 7 (Day), 1911 (Year)

AGE: ~~___ yrs. ___ mos. ___ ds.~~ If LESS than 1 day, ___ hrs. or 10 min.?

OCCUPATION
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 0

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

PARENTS

NAME OF FATHER: Earl Bryant

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

MAIDEN NAME OF MOTHER: Myrtle Farmer

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bess Farmer

(ADDRESS) New Bloomfield

Filed Dec 7, 1911 C. H. Christian REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 7 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 7, 1911, to Dec 7, 1911, that I last saw him alive on Dec 7, 1911, and that death occurred, on the date stated above, at 6 40 m.

The CAUSE OF DEATH* was as follows:

Premature Birth (5½ mo)

159 D

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

Contributory (SECONDARY) ✓

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

(Signed) Finis Suggett M. D.

Dec 7, 1911 (Address) New Bloomfield

*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: Private

DATE OF BURIAL: Dec 7, 1911

UNDERTAKER: None

ADDRESS: ✓

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

PLACE OF DEATH

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

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward) [If death ... hospital or ... give its N... of street an...

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

I HEREBY CERTIFY, that I attended dece

_____, 191__, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191__ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN... RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BUR...
UNDERTAKER	ADDRESS

Revised United States Standard Certificate of Death

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless im-