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 Ray

Township ____ or Village ____ or City Richmond (NO. ____, ____ St.; ____ Ward)

Registration District No. 744 File No. 37189

Primary Registration District No. 3035 Registered No. 201

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

FULL NAME Helen Bryant

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

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

DATE OF BIRTH: Nov 3 (Month) (Day), 1909 (Year)

AGE: 4 yrs. 7 mos. — 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): None

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

PARENTS
NAME OF FATHER: Henry Bryant
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentuckey
MAIDEN NAME OF MOTHER: Martha Sinsabaugh
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ray County

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Bryant

(ADDRESS) Richmond

Filed Nov 3, 1913. Geo W Hunt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 3 (Month) 4 PM (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 27, 1913, to Nov 2, 1913, that I last saw her alive on Oct 31, 1913, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Spinal meningitis as result of typhoid fever infection (typhoid) affecting the cord

(Duration) ____ yrs. ____ mos. 8 ds.

Contributory (SECONDARY) Typhoid Fever

(Duration) ____ yrs. ____ mos. 8 ds.

(Signed) E. T. McGaugh M. D.

11-3, 1913 (Address) Richmond

*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: City Cemetery

DATE OF BURIAL: Nov 3, 1913

UNDERTAKER: Stinnett & Co

ADDRESS: Richmond Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

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.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1_____
(Month) (Day) (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
_____, 191____
(Month) (Day) (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