

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 Pitts.
Township _____
or
Village _____
or
City Leola (NO. 2202 Bonnie St. _____ Ward _____)

Registration District No. 668 File No. 35951
Primary Registration District No. 3032 Registered No. 293

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

FULL NAME Granville Franklin Bryant

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE married
MARRIED married
WIDOWED married
OR DIVORCED married
(Write the word)
DATE OF BIRTH Mar 9, 1833
(Month) (Day) (Year)

AGE 84 yrs. mos. ds. IF LESS than
1 day, hrs. or min.?

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

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

PARENTS
NAME OF FATHER Andy Bryant
BIRTHPLACE OF FATHER VA
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER VA
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. F. Bryant
(ADDRESS) Leola Mo

Filed Nov 2, 1917, J B Long
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 31, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____,
that I last saw him alive on _____, 191____,
and that death occurred, on the date stated above, at 6 p. m.
The CAUSE OF DEATH was as follows:

Apoplexy
(Duration) 10 yrs. mos. ds.

Contributory
(SECONDARY) (Duration) yrs. mos. ds.
(Signed) W. H. Miller, Coroner M. D.
11-12, 1917 (Address) Leola 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 Crown Hill
DATE OF BURIAL Nov 2, 1917
UNDERTAKER Staley
ADDRESS Leola Mo

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

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

PLACE OF DEATH

County.....
Township.....
or.....
Village.....
or.....
City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

(NO.)

St.

Ward)

(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 (If "rite the word")
DATE OF BIRTH		
(Month) (Day) (Year) IF LESS than 1 day, ... hrs. or min. ?		
AGE		
..... yrs. mos. ds. (Month) (Day) (Year)		

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)

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
The CAUSE OF DEATH was as follows:

(Duration) yrs. mos. ds.

Contributory
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

..... (Address) M. D.

*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, TRANSIENT 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

UNDERTAKER

ADDRESS