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

Do not use this space.

35178

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. ..... St. ..... Ward)

File No. 10161

Registered No. .....

2. FULL NAME Patsy Ruth Bryant.

(a) Residence. No. 1022a N Newstead St., 11 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 2 1928

7. AGE — YEARS: — MONTHS: Oct — DAYS: 12 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Samuel Bryant.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Guthrie Ky.
(STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER Catherine Fort.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Guthrie
(STATE OR COUNTRY) Ky.

14. INFORMANT Samuel Bryant.
(Address) 1022a Newstead Ave.

15. FILED OCT 16, 1928 Max C Starkcof REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-14 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1928, to Oct 14, 1928, that I last saw her alive on Oct 14, 1928, and that death occurred, on the date stated above, at 9 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

100 (duration) yrs. mos. 12 ds.

CONTRIBUTORY (SECONDARY) 101W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptom

(Signed) S. E. Walthall, M. D

, 19 (Address) 1001 N Jefferson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Father Dickson

DATE OF BURIAL: 10-16 1928

20. UNDERTAKER: R. F. (Buddie) Walton

ADDRESS: 2701 Stoddard

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.