24

JUL 24 1929

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

Do not use this space.

20990

1. PLACE OF DEATH
County Clay
Township Fishing river
City ..... (No. ..... St. ..... Ward)
Registration District No. 198
Primary Registration District No. 2277 a
File No. .....
Registered No. 80

2. FULL NAME Andrew Jackson Bryan
(a) Residence. No. Brotherville St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE~~ OF Laura Bell Bryan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-7-1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	4	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stone mason
(b) General nature of industry, business, or establishment in which employed (or employer) ✓ ✓
(c) Name of employer ✓ ✓

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

PARENTS
10. NAME OF FATHER James Bryan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Susan McCrorkie
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Mo.

14. INFORMANT Claude Bryan (Address)

15. FILED 7/5 1929 Y. D. Crawford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-13 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to June 13, 1929, that I last saw him alive on June 13, 1929, and that death occurred, on the date stated above, at 2:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Regurgitation.
11 A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Influenza & Chronic Bronchitis.
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? physical & Lab finding
(Signed) S. R. McCracken, M.D.
, 19 (Address) Excelsior Springs Mo.

*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: Grown Hill
DATE OF BURIAL: June 16 1929
20. UNDERTAKER: Herbert Hope
ADDRESS: Excelsior Springs 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.