

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

Do not use this space.

37664

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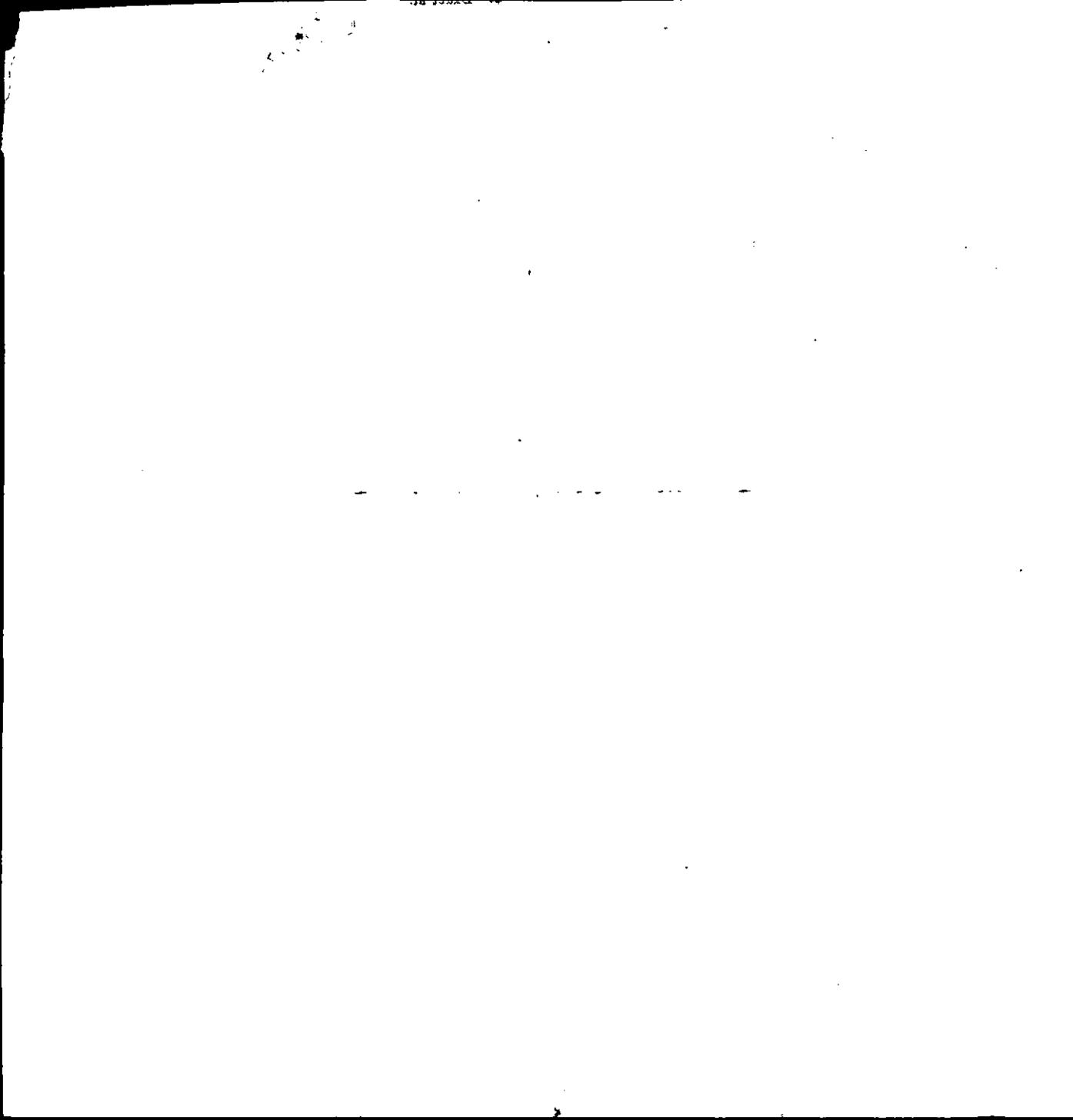
PLACE OF DEATH
 County Lawrence Registration District No. 468
 Town Marionville Primary Registration District No. 4281
 Full Name Jefferson Davis Bryant St. _____ Ward _____
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fanny Bryant
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 1861
 7. AGE YEARS MONTHS Days If LESS than 1 day, ____ hrs. or ____ min. 61 10
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Business
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____
 9. BIRTHPLACE (CITY OR TOWN) St. James City Mo (STATE OR COUNTRY)
 10. NAME OF FATHER James Bryant
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know (STATE OR COUNTRY)
 14. INFORMANT Mr. Fanny Bryant (Address)
 15. FILED 11-25, 1929 R. Andrews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1929
 17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1929 to Nov 20 1929 that I last saw him alive on Nov 20 1929, and that death occurred, on the date stated above, at _____
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Gastric Catarrh
 CONTRIBUTORY (SECONDARY) 11/20
 18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____
 19. DID AN OPERATION PRECEDE DEATH. DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS.
 (Signed) J.M. Pitterington, M. D. _____, 19 ____ (Address)
 *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 Marionville DATE OF BURIAL 11-22 1929
 20. UNDERTAKER Cradford's Funeral Home ADDRESS Marionville



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH:

County Lawrence Registration District No. 468 File No. _____
 Township _____ Primary Registration District No. 4281 Registered No. 27
 City Maryville (No. _____) St. _____ Ward _____

2. FULL NAME

Jefferson Davis Bryant
 (a) Residence No. _____ St. _____ 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 11 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 0 9

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
 (Address) _____

15. FILED 11-25, 1929 R. Andrews
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 that I last saw him _____ since on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

_____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*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 _____ DATE OF BURIAL _____

19

20. UNDERTAKER _____

ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-37664