

MAR 28 1930

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

Do not use this space.

1. PLACE OF DEATH

County Missouri
Township Charleston
City Charleston

Registration District No. 566
Primary Registration District No. 5742

File No. **5722**
Registered No. _____
St. _____ Ward _____

2. FULL NAME

William James 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. 7 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 28, 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
2 4

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) Detroit Michigan
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. Clyde Bryant

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

12. MAIDEN NAME OF MOTHER Rose Kathleen Couray

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

14. INFORMANT Mrs. W. C. Bryant
(Address) Charleston Mo.

15. FILED 2/1 1930 R. Marshall
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH 3:45 P.M.

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1 1 1930

17. I HEREBY CERTIFY, That I attended deceased from 1/28/30, 1930 to 2/1/30, 1930 that I last saw him alive on 2/1/30, 1930 and that death occurred, on the date stated above, at 3:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho Pneumonia

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY entirely (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at home
IF NO AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) R. Marshall, M. D.
2/1 1930 (Address) Wyatt 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 L.O.O.F. DATE OF BURIAL 2-3 1930

20. UNDERTAKER Fair Child Co. ADDRESS Charleston 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.

Dr. Marshall
Wyatt