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

Do not use this space.

No. 20562

1. PLACE OF DEATH

County St. Louis — Registration District No. 1123 — File No.

Township Carondelet — Primary Registration District No. 8248 B — Registered No. 193

City Jefferson Barracks, Mo. (No. U.S. Veterans Hospital, Jefferson Brks, Mo. Ward)

2. FULL NAME Edgar Bryant.

(a) Residence. No. 4242 West No. Market Str. St., Ward.
(Usual place of abode) St. Louis, Mo. (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	COLORED	Married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 3, 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	38	9	12	

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

9. BIRTHPLACE (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Mississippi.

PARENTS

10. NAME OF FATHER Unavailable.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.
12. MAIDEN NAME OF MOTHER Unavailable.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unavailable.
(STATE OR COUNTRY) Unavailable.

14. INFORMANT E. T. Gallagher, Clinical
(Address) E. T. Gallagher, Acting Director. U.S. Veterans' Hospital, Jefferson Barracks, Mo.

15. FILED 6/17 1930 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1929, 19..., to June 15, 1930, 19..., that I last saw him alive on June 15, 1930, and that death occurred, on the date stated above, at 11:00 AM. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Terminal Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Aneurism of Aorta; Lung Abscess.

(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? Yes.

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy, Physical & Laboratory findings.

(Signed) C. H. Smith, M.D.
(Address) Medical Officer In Temporary Charge. U.S. Veterans' Hospital, Jefferson Barracks, 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	DATE OF BURIAL
Greenwood Miss	6/19 1930
20. UNDERTAKER	**ADDRESS**
Hoffmeister U. & L. Co.	781 Ko Bdwy

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH

County St Louis — Registration District No. 1123 — File No. .....

Township Carondelet — Primary Registration District No. 6248 B — Registered No. 193

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Edgar 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. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

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)

PARENTS

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 10/10, 1930 L. C. Obrock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Terminal Pneumonia

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

CONTRIBUTORY (SECONDARY) Aneurism of aorta
Lung abscess, (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED (Empyema)
IF NOT AT PLACE OF DEATH? .....
Empyema is usually result
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? of Pneumonia
WHAT TEST CONFIRMED DIAGNOSIS? No evidence of TB.
(Signed) ..... M. D
....., 19 (Address) (abscess was not tuberculous)

*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

...STRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRES... BY LAW

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