

MAR 28 1937

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

Do not use this space.

9065

1. PLACE OF DEATH

County *Shannon*
Township *Custo*
City (No. _____) _____ St. _____ Ward _____

Registration District No. *1077*
Primary Registration District No. *6083*

File No. _____
Registered No. _____

2. FULL NAME

Minta Bryson
(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *female* 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 *Harry Bryson*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 1 - 1896*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
38 8 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Sharp Co Ark*

13. NAME *Lee Ralston*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

15. MAIDEN NAME *Addie Barnett*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Summersville Mo*

17. INFORMANT (ADDRESS) *Harry Bryson*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Summersville* DATE *Feb 7 - 1937*

19. UNDERTAKER (ADDRESS) *R.W. Day*

20. FILED 19 *L.H. Waller*
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 6 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Nov 1 1931* to *Feb 6 1937*

I last saw her alive on *Feb 4 1934* Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Paralytic

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) *L.H. Waller*, M. D.

(Address) *Summersville*

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.

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CERTIFICATE OF DEATH**

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1. PLACE OF DEATH

County Shannon
Township Casto
City _____ (No. _____, St. _____, Ward _____)

Registration District No. 1077
Primary Registration District No. 6083

File No. 9065
Registered No. _____

2. FULL NAME

Minna Bryson

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 8 6

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED 7/28 1937 J. B. McDaniel M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2 - 6 - 1934

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____

I last saw him _____ alive on _____ 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Myocardial Infarction
Progressive Bulbar Palsy

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____ 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) L. H. Waller M. D.
(Address) Summersville Ind

SUPPLEMENTAL

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.

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