

14  
2  
4  
14 SEP 20 1938

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

28480  
Do not use this space.

1. PLACE OF DEATH *Callaway 3*  
(a) County *Callaway 1* Registration District No. *104*  
(b) Township *Fulton* Primary Registration District No. *3028*  
(c) City *Fulton* (d) Street No. *State Street* Registered No. *203*  
(e) Length of residence in city or town where death occurred *0* yrs. *8* mos. *26* ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME *Alberta Bryan* *650*  
(a) Residence, No. *Malla Bend Mo* St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*  
6A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Robert L Bryan*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 1874*  
7. AGE YEARS *64* MONTHS *7* DAYS *7* If LESS than 1 day, .....hrs. or .....min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) *DK* 11. Total time (years) spent in this occupation *DK*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *States MO*

FATHER 13. NAME *Solomon King*

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

MOTHER 15. MAIDEN NAME *Sarah Casner*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *DK*

17. INFORMANT (ADDRESS) *Hosp. Records*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Malla Bend* DATE *Aug 17* 19*38*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Campbell-Lynn*  
*Man Hall Mo.*

20. FILED *8/16* 19*38* *R. N. Crews*  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 15* 19*38*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 1st* 19*78* to *Aug 15* 19*38*  
I last saw her alive on *Aug 15* 19*38* Death is said to have occurred on the date stated above, at *8 p* m.  
The principal cause of death and related causes of importance were as follows:

*Chn. Myocarditis & m. degeneration* Date of onset *DK*  
*980*

Other contributory causes of importance: *Sen. Arteriosclerosis* *DK*

Name of operation..... Date of.....  
What test confirmed diagnosis?..... Was there an autopsy? *No*

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 ordinary in any way related to occupation of deceased? *No*  
If so, specify *Lakop Knis* (Signed) *Lakop Knis*, M. D.  
(Address) *Fulton 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.

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**