

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

1865
Do not use this space.

FILED FEB 12 1940

1. PLACE OF DEATH

(a) County Callaway Registration District No. 104
 (b) Township 7 Primary Registration District No. 3008
 (c) City Fulton Mo (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. 5 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. State Hospital no 1 St. Otterville Mo
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>		4. COLOR OR RACE <u>white</u>		5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs Nellie Bryan</u>					
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>24</u>					
7. AGE YEARS <u>63</u>		MONTHS <u>?</u>		DAYS <u>2</u>	
If LESS than 1 day, _____ hrs. or _____ min.					
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>				
	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)				
11. Total time (years) spent in this occupation					
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>					
FATHER	13. NAME <u>Thomas Bryan</u>				
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Vergennes</u>				
MOTHER	15. MAIDEN NAME <u>Unknown</u>				
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>"</u>				
17. INFORMANT <u>Mrs Albert Bryan</u> (ADDRESS)					
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Otterville, Mo</u> DATE <u>Feb - 9</u> 19 <u>40</u>					
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Parker Funeral Home</u> <u>Otterville, Mo.</u>					
20. FILED <u>1130</u> 19 <u>40</u> <u>R. M. Cresce</u> Local Registrar.					

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 29 1940

22. I HEREBY CERTIFY That I attended deceased from Jan 24 1940, to Jan 29 1940
 I last saw him alive on Jan 29 1940 Death is said to have occurred on the date stated above, at 9:45 m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Arterio sclerosis with psychosis
 Date of onset _____

Other contributory causes of importance:
hypertension

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 James Thomas Bryan
 (Signed) _____ M. D.
1065 (Address): State Hospital # 1

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. *myself*

Signed *Lucius F. Parker*
Licensed Embalmer No. *3840*
P. O. Address *Otterville, Mo*

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.