S. No. 2
—11-10-39
v. 5-17-39
I X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1940

Registration District No.

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 8674

Primary Registration District No.

Registrar's No. 2157

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Homer Phillips (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or Institution 3 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County

(c) City or town St Louis (If outside city or town limits, write "RURAL") 21

(d) Street No. 917 No Euclid (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John O'Bryant

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Col

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years 69 Months Days If less than one day hr. min.

9. Birthplace Mo (City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business

MOTHER FATHER

12. Name Unknown

13. Birthplace " (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name "

15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant Clyde Pepper - F. D.

(b) Address 6201 Clayton

17. (a) (Burial, cremation, or removal) (b) Date thereof 2-9-40 (Month) (Day) (Year)

(c) Place: burial or cremation St Louis

18. (a) Signature of funeral director Chas Kuntz

(b) Address 3100 Kingsh

19. (a) MAR 4 1940 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 30 year 1940 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to: Apoplexy	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Joseph M. Lucas (M. D. or other)

Address Deputy Coroner Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.