

No. 2
7-10-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16571

State File No. _____

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Vermont

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

(c) Name of hospital or institution:
State Hospital #3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 mos 27 days
(Specify whether

In this community UNKNOWN
years, months or days)

3. (a) PRINT FULL NAME Archibald Frank Bryant

3. (b) If veteran, name war UNKNOWN

3. (c) Social Security No. unknown

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Fannie Cook

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

7. Birth date of deceased 11 29 1861
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Musician

11. Industry or business _____

MOTHER FATHER { 12. Name David Bryant

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

14. Maiden name Mary Paderra

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

16. (a) Informant State Hospital #3 Records

(b) Address Nevada 7770

17. (a) Reburied (b) Date thereof 4/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Tamar, Mo

18. (e) Signature of funeral director Mary Eichinger

(b) Address Nevada, Mo

19. (a) 4-11-1940 (b) Allen V. Kaye
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Barton

(c) City or town Lamar
(If outside city or town limits, write "RURAL")

(d) Street No. UNKNOWN
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 2
year 1940 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-5, 1940, to 4-2, 1940, that I last saw him alive on 4-2, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Due to _____

Due to _____

Other conditions General arteriosclerosis
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? 705
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address State Hosp #3 Date signed 4/3/40

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

RECEIVED
District Health Officer No. 7,
District File Number 5-40-723
Date Filed 5-6-40

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 Mark Eichinger
Licensed Embalmer No. 2656
P. O. Address Nevada 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16371

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town Washington, T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Archibald F Bryant

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased 11-29-1861
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>78</u>	<u>7</u>	<u>4</u>	<u>3</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 2
year _____ hour _____ minute _____ M.

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

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature F.C. Long (M. D. or other) _____

Address W Nevada Ave Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

