

C 12 1940

89

Registration District No.

Primary Registration District No.

5131 C

Registrar's No.

363

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

1. PLACE OF DEATH:

(a) County Butler Mo RI
 (b) City or town Fresh Mo RI
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Asa Hill Farm
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
(Specify whether
 In this community 2
years, months or days)

3. (a) PRINT FULL NAME Clara M. Bryant

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

4. Sex Female 5. Color or race White

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov - 28 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Starbuck Co Ind
(City, town, or county) (State or foreign country)

10. Usual occupation Farm wife

11. Industry or business _____

12. Name Richard Hoffmann

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

14. Maiden name Louise C. McGill
(City, town, or county) (State or foreign country)

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

16. (a) Informant H W Bryant
 (b) Address Fresh Mo RI

17. (a) Burial Date thereof Dec 1 40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucas

18. (a) Signature of funeral director Walter Fumler
 (b) Address 1724 E. 1st St

19. (a) 12/2/40 (b) Blutinger
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Butler
 (c) City or town Fresh Mo RI
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1
 year 1940 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from 8:45 P.M.
Dec 1 1940 to 9:20 P.M. Dec 1 1940
 that I last saw her alive on Dec 1 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Stomach poisoning
 Duration 2 1/2 hrs

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 cause, 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 R. E. Farley (M. D. or other) _____
 Address Lucas Date signed Dec 2 1940

PHYSICIAN

Underline the cause to which death should be charged statistically.

1799-
19

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.....

Virgil H. Helch

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Virgil H. Helch*

Licensed Embalmer No. *4102*

P. O. Address *Dexter, 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. 38262⁷
Registrar's No. 363

Registration District No. 89

Primary Registration District No. 5131C

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

1. PLACE OF DEATH:
 (a) County Butler
 (b) City or town Cash Hill Mo.
 (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 Clara M. Bryant
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced _____
 6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 73 Months _____ Days 7 If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (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 Dec day 1 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 Stomach poisoning only saw her 30 minutes before death and found the symptoms believe it to be Stomach poisoning No one else was affected
 Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy 177 19

Duration _____
 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 R. G. Farpley (M. D. or other) _____
 Address Gish Date signed Feb 5/1941

SUPPLEMENTAL

Registration District No. 89

Primary Registration District No. 5131

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Wash Hill TIO
(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: 1h in hospital or institution (Specify whether

In this community

years, months or days

3. (a) PRINT FULL NAME Clara M. Bryant

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife G.W. BRYANT 6. (c) Age of husband or wife if alive 66 years

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

8. AGE: Years 73 Months 7 Days _____ If less than one day _____ min.

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

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 6/4/41 (Date received local registrar) (b) Kate Lutz (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) Citizen of foreign country _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 1 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 _____

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 9 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?

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

23. Signature P. F. Tarpley (M. D. or other)

Address Frank Date signed _____

SUPPLEMENTAL REPORT

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

ROWENA MOORE

5/29