

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40982
10753
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days. (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Loy Daniel Brant

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Grace Brant 6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased July 21, 1901
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>7</u>	<u>21</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Dan Brant

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

14. Maiden name Anna Statler

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

18. (a) Informant's own signature Mrs. Grace Brant

(b) Address Chaffee Missouri

17. (a) Burial (b) Date thereof Dec 29 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau Mo.

18. (a) Signature of funeral director W. H. Bradley

(b) Address Cape Girardeau Mo.

19. (a) DEC 28 1940 (b) J. H. Brudwick
(Date and time of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County Scott
(c) City or town CAPE GIRARDEAU N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. 419 SOUTH FREDERICK
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27
year 1940 hour 8 minute 25 P. M.

21. I hereby certify that I attended the deceased from 7
12-16, 1940 to 12-27, 1940;
that I last saw him alive on 12-27, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia
Meningioma, benign

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 J. H. Bradley (M. D. or other) _____

Address BARNES HOSPITAL Date signed 12-28-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 X1081

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St. Louis 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.