

No. 2
11-1-1933
17-1-1933
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27641

State File No. _____

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 202

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
University Hospitals. D
(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

2. USUAL RESIDENCE OF DECEASED: 14

(a) State Missouri (b) County 5

(c) City or town Millersburg 0
(If outside city or town limit, write "RURAL")

(d) Street No. R.F. 10. 5#
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Mrs. Ocie Bryant.

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

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

6. (b) Name of husband or wife Mrs. Joseph C. Bryant. 6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased June 24 - 1902
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Oblong (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name Mr. J. M. Watt

13. Birthplace Order City, Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Sallie Watt

15. Birthplace Mokane, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph Bryant
(b) Address New Bloomfield Mo.

17. (a) Reburied (b) Date thereof Aug 29, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fulton Mo

18. (a) Signature of funeral director J. J. Blalock
(b) Address Fulton, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
year 1943 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Aug 27, 1943 to Aug 29, 1943
that I last saw her alive on Aug 29, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Shock
following cerebral
relaxation of the cerebral
due to fat embolism of
pregnancy
due to Chloroform anesthesia
nephritis

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

Duration

PHYSICIAN

Major findings:
Of operations 1448

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? _____
(Specify type of place)

While at work _____
(Specify type of place)

23. Signature D. T. Keiser (M. D. or other) 4
Address Columbia, Mo. Date signed 8/29/43

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

MAR 29 1945

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 Geo. P. Maloney
Licensed Embalmer No. 3373
P. O. Address Fulton, 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.

SEP 9 1943

No. 2B
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 202

Registration District No. 28 Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(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 Ocie 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 m

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

7. Birth date of deceased: June 24 1910
(Month) (Day) (Year)

8. AGE: Years 42 Months 2 Days 2 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8/31/43 (b) E. P. Laster
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 1943 year 29 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her 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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

FILED

27641