

FILED OCT 29 1943 333

6115

Registration District No. 333

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Rockland 3 Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Canaan R. 1
(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 Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Rural 072
(If outside city or town limits, write "RURAL.")

(d) Street No. Canaan Mo R. 1 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM A. BRYANT

3. (b) If veteran, name war L

3. (c) Social Security No. —

4. Sex Male

5. Color or race Caucasoid

6. (a) Single, widowed, married divorced

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

7. Birth date of deceased: 1877
(Month) (Day) (Year)

8. AGE: Years 66 Months Days If less than one day
hr. min.

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

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER {

12. Name D.K. 9

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

14. Maiden name D.K. 9

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

16. (a) Informant Lewis Bryant

(b) Address Matthews Mo 171

17. (a) Burial (b) Date thereof 7/15/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Summit Cemetery - District No.

18. (a) Signature of funeral director Welsh Funeral Home

(b) Address District Mo

19. (a) Oct 24 1943 (b) Leone Largent
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from June 1
1943, to July 13, 1943
that I last saw him alive on July 6, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis

Due to

Due to

Other conditions Myocarditis
(include pregnancy within 3 months of death)

Major findings: 93%

Of operations

Of autopsy

Duration

X

X

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 0

23. Signature E E Jones (M. D. or other)

Address Belbourn Mo Date signed 8-13-43

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

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address. Sikeyton 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, fact should be so stated above.

Registration District No. 1603

Primary Registration District No. 799

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Canavan Rural
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Wth A. Bryant

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

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

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 66 Months Days If less than one day..... min.

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

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) (Date received local registrar) (b) Mae Brown (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..... Day..... Year 1943 M.....

21. I hereby certify that I attended the deceased from..... 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 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?.....

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

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

Address..... Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

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