

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Sikeston, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **none**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sherman Bryant**
3. (b) If veteran, name war _____ No. _____
3. (c) Social Security No. _____

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

7. Birth date of deceased **June 7 1870**
(Month) (Day) (Year)

8. AGE: Years **74** Months **1** Days _____ If less than one day _____ hr. _____ min.

9. Birthplace **Raleigh N.C.** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **Peter Bryant**

13. Birthplace **Raleigh N.C.** (City, town, or county) (State or foreign country)

14. Maiden name **Helle Shippen**

15. Birthplace **Raleigh N.C.** (City, town, or county) (State or foreign country)

16. (a) Informant **Josephine Bryant**
(b) Address **Sikeston, Mo.**

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

(c) Place: burial or cremation **Sunset cemetery**

18. (a) Signature of funeral director **Mattie Smith**

(b) Address **1381 Maud St. Sikeston, Mo.**

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

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Scott**
(c) City or town **Sikeston** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **8th** year **1944** hour **2** minute **30 AM.**

21. I hereby certify that I attended the deceased from **Mar 10th** 1944 to **June 5** 1944 that I last saw him alive on **June 5** 1944 and that death occurred on the date and hour stated above.

Immediate cause of death **chronic nephritis** Duration _____

Due to **hypertension**

Due to _____

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

Major findings: Of operations **131h**

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) (c) Means of injury _____

23. Signature **Noble R. Elish M.D.** (M. D. or other) _____
Address **1381 Maud St. Sikeston, Mo.** Date signed **6-10-44**

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

1941 9 11 WAR

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 *Wm. Smith*.....

Licensed Embalmer No. *4371*

P. O. Address *# 27 Sikeston*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

Registration District No. 233

Primary Registration District No. 3074

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Liberation
(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 Sherman Bryant

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

4. Sex M 5. Color or race B 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: June 7 (Month) (Day) (Year)

8. AGE: Years 74 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Peter Bryant

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 Josephine Bryant

(b) Address ms.

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6/19/44 (b) Laurie Largent
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Scott
(c) City or town Liberation
(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 June day _____
year 1944 hour _____ minute _____ 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 _____

SUPPLEMENTARY

MOTHER FATHER

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

B
3
36930

19252