

Primary Registration District No. 3007

1. PLACE OF DEATH:  
(a) County Butler  
(b) City or town Poplar Bluff  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Brandon Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
Specify whether  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Stoddard  
(c) City or town Dexter  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Albert Leroy Bryte  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 14  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 17, 1871  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb. 5, 1945 to Feb. 14, 1945  
that I last saw him alive on Feb. 14, 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 2 Days 27  
If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Cerebral hemorrhage  
Due to Hypertension

9. Birthplace Prairie City Ill.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Dentist

Due to chronic nephritis  
Other conditions   
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name William Bryte  
13. Birthplace No record  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Beam  
15. Birthplace No record  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

16. (a) Informant Leo Buck  
(b) Address 3915a Russell, St. Louis, Mo  
17. (a) Removal (b) Date thereof 2-14-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Avon, Ill.

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? \_\_\_\_\_

18. (a) Signature of funeral director Blankenship-Strickland  
(b) Address Dexter, Mo.  
19. (a) 2-22-45 Belle Drupe  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other)  
Address Poplar Bluff, Mo Date signed 2-19-45

Duration 2 1/3 / 45  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

12  
7  
3

RECEIVED

District Health Office No. \_\_\_\_\_

District File Number 345-30

Date Filed 3/8/45

APR 20 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 *J. Sturtevant*  
Licensed Embalmer No. 3479  
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, fact should be so stated above.