No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1945

Registration District No. 78

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9536

State File No.

Primary Registration District No. 4159

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Daviess Co ~~Benton~~

(b) City or town Pattonsburg ~~Rural~~ ~~Miller~~
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Dr L. Z. Parker Office
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether)

In this community ~~Lifetime~~ Few Minutes
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry 38

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

(d) Street No. Rural Miller Twp.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Lloyd Dwaine Bryant

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 ✓

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased Oct 8 - 1943
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business ✓

FATHER
12. Name Artie Bryant
13. Birthplace Gentry Co Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Wanda Gates
15. Birthplace Phillips Co Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Artie Bryant
(b) Address Pattonsburg Mo Rural

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-45
(Month) (Day) (Year)

(c) Place: burial or cremation Pattonsburg, Mo.

18. (a) Signature of funeral director J. S. Trosper
(b) Address Pattonsburg Mo.

19. (a) 2-10-1945 (Date received local registrar) (b) L. O. Richesson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25
year 1945 hour 10 minute A M.

21. I hereby certify that I attended the deceased from Come into the Office, 19 to Jan 25, 1945;
that I last saw him alive on Jan 25, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death

Accidentally

Due to Eating aspirin's Tablets 15 tablets of 15 gr each

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 03

(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? (e) Means of injury

23. Signature John Z. Parker (M. D. or other)

Address Pattonsburg Date signed 1/28/45

1084 (Licensed Embalmer's Statement on Reverse Side)

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 G S Gramer

Licensed Embalmer No. 2857

P. O. Address Pattonsburg MO

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

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

S. No. 2B
M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 98 Primary Registration District No. 4159 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Daviess

(b) City or town Pattonsburg
(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)

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

3. (a) PRINT FULL NAME Lloyd D. Bryant

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct 8 1945
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days 17 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace
(City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day 25
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) This Child ate 15 5 gr. aspirin tablets

(b) Date of occurrence June 25/45

(c) Where did injury occur? at his home Gentry MO
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In the Home or the Farm.
(Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address [illegible] Date signed

SUPPLEMENTARY

95336