

No. 2
1-5-43
5-17-39
1 X35671

FILED JUN 7 1945
Registration District No. 272

Primary Registration District No. 2053

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Roca

(c) Name of hospital or institution McFarland Hospital
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 2 1/2 weeks
In this community 40 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby

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

(d) Street No. West Highway 66
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Dr. Walter Jerome Bryant

3. (b) If veteran name was Spanish War

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2
year 1945 hour 6 minute 53 A. M.

21. I hereby certify that I attended the deceased from April 15, 1945 to May 2, 1945
that I last saw him alive on May 2, 1945
and that death occurred on the date and hour stated above.

4. Sex W 5. Color or race W

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

6. (b) Name of husband or wife Mrs Effie Bryant

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

7. Birth date of deceased: Sept 11 1871
(Month) (Day) (Year)

Immediate cause of death Shock

Due to Surgery: Appendectomy and cholecystectomy

Due to _____

8. AGE: Years 73 Months 7 Days 21
If less than one day hr. _____ min. _____

Other conditions Fractured patella, and proximal end of tibia (right) and injuries to gell
Major findings: bladder rupture as result of fall.

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Real Estate (Retd)

11. Industry or business _____

12. Name Osibury Bryant

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

14. Maiden name Marney Starved

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

16. (a) Informant Mrs Effie Bryant

(b) Address Roca Mo

17. (a) Burial (b) Date thereof 5-4-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Roca Mo

18. (a) Signature of funeral director Walter J. Starved

(b) Address Roca Mo

19. (a) 5-7-45 (b) Walter J. Starved
(Date received local registrar) (Registrar's signature)

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 _____

Signature Walter J. Starved (M.D. or other) _____

Address Roca Mo Date signed 5/7/45

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

Supplemental Information Requested

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 WME

....., Registered Apprentice No.
working under my personal supervision.

Signed D. L. Murrell

Licensed Embalmer No. 3394

P. O. Address Reese mo

JUN 8 1945

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June
Registrar's No. _____

Registration District No. 1275

Primary Registration District No. 3053

1. PLACE OF DEATH

(a) County Phelps
(b) City or town Polla
(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 Sylvester J. 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 m

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

7. Birth date of deceased Sept 11 (Month) (Day) (Year)

8. AGE: Years 73 Months _____ Day _____ If less than one day _____ hr. _____ min.

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

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 Mar Day _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

(that I last saw him _____ 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 _____ 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) Accident approx 1/2

(b) Date of occurrence About 2 wks before hospitalization

(c) Where did injury occur? Polla Phelps Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public place

While at work _____ (Specify type of place) _____

Means of injury _____

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

Address Polla, Mo. Date signed 6-27-45

SUPPLEMENTARY

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

MOTHER FATHER

17809