

FILED OCT 8 1945
Registration District No. 128

Primary Registration District No. 2000

778

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **935 TEXAS**
(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 **MO.** (b) County **GREENE, 39**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **935 TEXAS**
(If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CLYDE JUNIOR BRYANT**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**

6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive **XX** years

7. Birth date of deceased **April 26, 1945**
(Month) (Day) (Year)

8. AGE: Years **0** Months **5** Days **2** If less than one day
hr. min.

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

10. Usual occupation **Infant**

11. Industry or business **At Home**

12. Name **Clyde Bryant**

13. Birthplace **Reeds Spring MO.**
(City, town, or county) (State or foreign country)

14. Maiden name **Lilly Nimmo**

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

16. (a) Informant **Clyde Bryant**

(b) Address **SPRINGFIELD MO.**

17. (a) **Burial** (Burial, cremation, or removal) Date **Sept. 30, 45**
(Month) (Day) (Year)

(c) Place: burial or cremation **Springfield**

18. (a) Signature of funeral director **W. Klingner & Co.**
(b) Address **SPRINGFIELD MO.**

19. (a) **9-29-45** (Date received local registrar) (b) **W. H. Handley** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **Sept.** day **28** year **1945** hour **7** minute **40 P.M.**

21. I hereby certify that I attended the deceased from **9/27/45** to **9/28/45** 19 **45**
that I last saw him **dead** on **9/28** and that death occurred on the date and hour stated above.

Immediate cause of death **Bacterial enteritis** Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations **None**

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 **W. H. Handley** (M. D. or other) _____

Address **Springfield Mo.** Date signed **9/28/45**

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

9
2
6

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

Licensed Embalmer No. *4071*

P. O. Address *Springfield*

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.