

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 139

Registration District No. 150

Primary Registration District No. 5572

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Prairie Inn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson County E. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month
(Specify whether years, months or days) 25 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Hodson
(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 Katie Bryan

3. (b) If veteran, name war _____ (c) Social Security No. 2

4. Sex Female 5. Color or race wh. 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Palmer Bryan 6. (c) Age of husband or wife if alive 1st 1903

7. Birth date of deceased March 1st 1909
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>42</u>	<u>7</u>	<u>25</u>		hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name James Wilson

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

14. Maiden name Sarah Graves

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

16. (a) Informant Katie Bryan

(b) Address Hospital Records

17. (a) Burial (b) Date thereof 10/29/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O'Fallon

18. (a) Signature of funeral director Garrod Hanch

(b) Address 3024 Frost

19. (a) 10-27-46 (b) Doro G. Cane
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Sept. 26-1945 to Oct. 26-1945
that I last saw her alive on Oct. 26-1945, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac fibrillation

Due to Dr. Shepard
Due to lost operation

Other conditions (include pregnancy within 3 months of death) 638

Major findings of autopsy Dr. Shepard
Resistant to treatment
Of autopsy _____

Duration

1 hr

6 mos

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 working _____ (Specify type of place)
Means of injury _____
23. Signature Dr. Shepard
Address 300 Park Blvd

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

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.....

P. O. Address.....

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.