

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24113

FILED AUG 7 1947

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3111

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Baress City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days
(Specify whether years, months or days) 10 days

In this community _____
years, months or days

3. (a) PRINT FULL NAME John W. Bryce

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 Married

6. (b) Name of husband or wife Ida M. Bryant Bryce

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

7. Birth date of deceased: October 31, 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>02</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Retired Miner

11. Industry or business Coal Mining

MOTHER FATHER

12. Name Hobson John Bryce

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

14. Maiden name Hobson Maggie

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

16. (a) Informant Hospital Records

(b) Address St. Joseph Hosp., K.C., Mo.

17. (a) Removal (Burial, cremation, or removal)

(b) Date thereof July 24, 1947
(Month) (Day) (Year)

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

18. (a) Signature of funeral director Thurman Funeral Home

(b) Address Richmond, Mo.

19. (a) 7-24-47 (Date received local registrar)

(b) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

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

(d) Street No. RR #2
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1947 hour 1:40 P.M. M.

21. I hereby certify that I attended the deceased from July 14 - 47, 1947 to date, 1947; that I last saw him alive on today, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia

Due to Bowel obstruction

Due to Post-operative adhesion

Other conditions: _____
(Include pregnancy within 3 months of death) 12 2 1/2

Major findings: _____

Of operations: Bowel obstruction

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 Vernon Williams (M.D. or other) _____

Address 836 Angell Blvd., K.C., Mo. Date signed July 26

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

DEC 18 1957

MAY 18 1948

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..... *E. Thurman*

Licensed Embalmer No. *2073*

P. O. Address. *Richmond, 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.