

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 13 1949

State File No. 24652
6715

BIRTH NO. 24238-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			d. STREET ADDRESS (If rural, give location) 27-2953 Thomas Street		
3. NAME OF DECEASED (Type or Print) Vera Louise Bryant			4. DATE OF DEATH (Month) (Day) (Year) July 31, 1949		
5. SEX female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH April 22, 1949		9. AGE (In years last birthday) 0 Months 3 Year 9 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nile		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	

13a. FATHER'S NAME Joseph Bryant		13b. MOTHER'S MAIDEN NAME Ivory Bryant		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ivory Bryant 2933 Thomas St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Status Lymphaticus Thyroidicus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 64	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 273X	

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

22a. SIGNATURE Joseph M. Dement, Colonel (Degree or title)		22b. ADDRESS 1300 Chestnut		22c. DATE SIGNED 8/1/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Aug. 3, 1949		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Dement & Son		ADDRESS 2629-31 Cole Street	

DATE REC'D BY LOCAL REG. AUG 2 1949 REGISTRAR'S SIGNATURE J. B. Jasater (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No.

working under my personal supervision.

Emb. filed. signed

Student
Student Embalmer

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.