

FILED SEP 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30737
Registrar's No. 356

BIRTH NO. _____ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, write RURAL and give township) Independence
c. LENGTH OF STAY (in this place) 5 1/2
d. FULL NAME OF HOSPITAL OR INSTITUTION 401 So Osage

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY (If outside corporate limits, write RURAL and give township) Independence
d. STREET ADDRESS (If rural, give location) 401 So Osage

3. NAME OF DECEASED
a. (First) Clyde b. (Middle) S. c. (Last) Bryant
4. DATE OF DEATH (Month) (Day) (Year) Sept 7-50

5. SEX male 6. COLOR OR RACE wh 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH Dec 19-1889 9. AGE (In years last birthday) 60 10. MONTHS 00 11. DAYS 00 12. HOURS 00 13. MIN. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filling Station - Operator
10b. KIND OF BUSINESS OR INDUSTRY Operator
11. BIRTHPLACE (State or foreign country) Indep Mo.
12. CITIZEN OF WHAT COUNTRY? 0

13a. FATHER'S NAME John T. Bryant 13b. MOTHER'S MAIDEN NAME Amanda S. Satterton 14. NAME OF HUSBAND OR WIFE none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME Ella Bryant, Ind, Mo ADDRESS

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) cerebral hemorrhage
ANTECEDENT CAUSES
DUE TO (b) High blood pressure
DUE TO (c) 331X
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arricular fibrillation 2 yrs.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

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)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

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 _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Name of (1)(a)) William W. Carter MD 23b. ADDRESS 3135 Liberty 23c. DATE SIGNED Sept 7-1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Sept 9, 1950 24c. NAME OF CEMETERY OR CREMATORY Blue Springs 24d. LOCATION (City, town, or county) (State) Blue Springs Mo.

DATE REC'D BY LOCAL REG. Sept 8, 1950 REGISTRAR'S SIGNATURE 354 25. FUNERAL DIRECTOR'S SIGNATURE OH & Mitchell ADDRESS Indep, Mo

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

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SEP 18 RECD

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 me

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Henry J. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep. 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.