

No. 300
10-48

FILED NOV 10 1951

STANDARD CERTIFICATE OF DEATH

State File No. **38089**

BIRTH NO. _____ REG. DIST. NO. **100** PRIMARY REG. DIST. NO. **3018** Registrar's No. **72**

331

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

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem		c. CITY (If outside corporate limits; write RURAL and give township) OR TOWN Salem	
c. LENGTH OF STAY (In this place) 5 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION none		d. STREET ADDRESS (If rural, give location) ---	

3. NAME OF DECEASED (Type or Print) Spurgeon Bryant			4. DATE OF DEATH 10/14/51		
a. (First)		b. (Middle)	c. (Last)		

5. SEX male	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 28 1891		9. AGE (In years last birthday) 60	10. UNDER 1 YEAR	11. UNDER 5 YEARS	12. UNDER 10 YEARS	13. UNDER 15 YEARS	14. UNDER 18 YEARS
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg Constr.		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
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13a. FATHER'S NAME John Bryant		13b. MOTHER'S MAIDEN NAME Sarah Bryant		14. NAME OF HUSBAND OR WIFE Marie Bryant	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME Marie Bryant, Salem, Missouri		ADDRESS	
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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) Chromocystoma disease varicella ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH unknown	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION no operation 4221		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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	
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22. I hereby certify that I attended the deceased from **5/22 1951**, to **10/19/51**, that I last saw the deceased alive on **10/13/51**, and that death occurred at **4:00a** m., from the causes and on the date stated above.

23a. SIGNATURE L.H. Hunt - M.D. (Degree or title)		23b. ADDRESS Salem, Mo		23c. DATE SIGNED 10/16/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/16/51		24c. NAME OF CEMETERY OR CREMATORY Miner Cemetery		24d. LOCATION (City, town, or county) (State) Dent County, Missouri	
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DATE REC'D BY LOCAL REG. 11/4/51		REGISTRAR'S SIGNATURE M.M. Hart, M.D. by J.K.		25. FUNERAL DIRECTOR'S SIGNATURE Carl K. Spencer		ADDRESS Missouri	
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THE No. _____
DISTRICT HEALTH OFFICE No. 4

NOV - 8 1951

RECEIVED

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.

Student
Student Embalmer

Signed Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, 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.