

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9751**
2477

FILED MAR 29 1952

BIRTH NO. _____ 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 MO. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2119	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4546^{1/2} N. Market	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4546^{1/2} N. Market			

3. NAME OF DECEASED (Type or Print) Ardenia		a. (First) ARDENIA b. (Middle)	c. (Last) BRYANT	4. DATE OF DEATH (Month) (Day) (Year) Mar 11 1952
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 5, 1898	9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Miss	12. CITIZEN OF WHAT COUNTRY? 1

13a. FATHER'S NAME Frank Seales	13b. MOTHER'S MAIDEN NAME Louise	14. NAME OF HUSBAND OR WIFE James Bryant
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS James Bryant 4546^{1/2} N. Market

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Colon e Metastasis		DUE TO (b)		6 mos.
ANTECEDENT CAUSES		DUE TO (c)		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Hypertension		Unknown
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 153X

22. I hereby certify that I attended the deceased from **March, 1946**, to **3-10, 1952**, that I last saw the deceased alive on **3-10, 1952**, and that death occurred at **1:10 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE A. E. Smith, M.D. (Degree or title)	23b. ADDRESS 11 N. Jefferson	23c. DATE SIGNED 3-14-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Mar 15 52	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis MO
DATE REC'D BY LOCAL REG. MAR 15 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. GENERAL DIRECTOR'S SIGNATURE ADDRESS J. A. Green 4214 Delmar	

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.

Student
Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Dolmar

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.