

FILED NOV 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35997**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1204			
1. PLACE OF DEATH a. COUNTY Buchanan.				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri				b. COUNTY Jackson.	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (in this place) 2 yrs. 4 mo. 21 days		c. CITY OR TOWN Kansas City		d. Residences within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No. 2.				e. STREET ADDRESS (If rural, give location) 2400 E. 9th		3178			
3. NAME OF DECEASED (Type or Print) a. (First) MARGARET			b. (Middle) ADELL		c. (Last) BRYANT.		4. DATE OF DEATH (Month) (Day) (Year) 11-11-1955.		
5. SEX Female.	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated.	8. DATE OF BIRTH 4-15-1895.		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 6 Days 26	IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Homemaking		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME John Burke.			13b. MOTHER'S MAIDEN NAME Mary T. Collier.			14. NAME OF HUSBAND OR WIFE Frank O. Bryant.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Records, State Hosp #2				ADDRESS St. Joseph, Mo.	
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) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 5 days	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis				19. unknown.	
				DUE TO (c) 4222					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 11-11-1949 , to 11-11-1955 , that I last saw the deceased alive on 11-10-1955 , and that death occurred at 3:30 A. M. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) C. G. Carver, M.D.				23b. ADDRESS State Hospital No. 2 St. Joseph, Mo.			23c. DATE SIGNED 11-11-1955.		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-13-55	24c. NAME OF CEMETERY OR CREMATORY Kirksville Anatomical School		24d. LOCATION (City, town, or county) (State) Kirksville, Missouri				
DATE REC'D BY LOCAL REG. Nov 16, 1955		REGISTRAR'S SIGNATURE Lothar M. Allison		FUNERAL DIRECTOR'S SIGNATURE Stamey Funeral Home		ADDRESS St. Joseph, Mo.			

(Licensed Embalmer's Statement on Reverse Side)

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

JUL 14 1959

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.....
Signature of Student Embalmer

Signed *Charles E. Bennett*

Licensed Embalmer No. *46*

P. O. Address *St. Joseph*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.