

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29272

STATE FILE NUMBER 7569

FILED AUG 26 1957

318

1003

Registration District No. Primary Registration District 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, give TOWNSHIP only) Inside Limits OR TOWN ST. LOUIS, MO. Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSH. #1. Length of stay in 1b		STREET ADDRESS 3943 Keokuk (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) **JAMES BRYANT** First Middle Last
4. DATE OF DEATH **AUG. 12, 1957** Month Day Year

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH **April 17, 1879** 9. AGE (In years last birthday) **78** IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Watchman** 10b. KIND OF BUSINESS OR INDUSTRY **Retired** 11. BIRTHPLACE (City and state or country) **Unk. Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **James Bryant** 14. MOTHER'S MAIDEN NAME **Mattie Patterson**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. **Unk.** 17. INFORMANT Address **Clifton Compton, 3943 Keokuk**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): **Pneumococcal Pneumonia**
Conditions, if any, which gave rise to above cause (a):
DUE TO (b):
DUE TO (c): **490X**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Cerebral Arteriosclerosis - left hemiplegia (old)
INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES NO 2

20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **7/26/57** to **8/12/57** and last saw her alive on **8/12/57**
Death occurred **9:12 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Samuel R. Joseph M.D.** 22b. ADDRESS **1515 LAFAYETTE AVE.** 22c. DATE SIGNED **8/13/57.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **8-13-57** 23c. NAME OF CEMETERY OR CREMATORY **Memorial** 23d. LOCATION (City, town, or county) (State) **Pontiac, Ill.**

24. FUNERAL DIRECTOR ADDRESS **McLaughlin Funeral Home, Inc.** 25. DATE RECD. BY LOCAL REG. **AUG 13 57** 26. REGISTRAR'S SIGNATURE **J. Carl Smith MD**

2301 Lafayette, St. Louis, Mo. (Licensed Embalmer's Statement on Reverse Side)

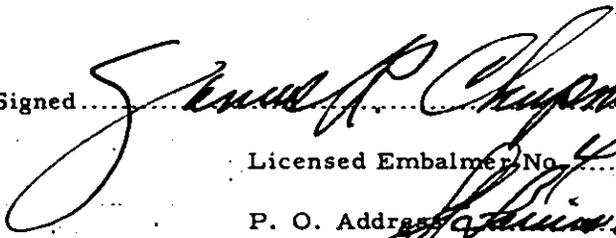
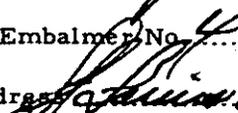
Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 
Licensed Embalmer No.
P. O. Address 

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.