Health, Welfare Public Service

300 1-57

THE DIVISION OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

59-005457
STATE FILE NUMBER

FILED FEB 19 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 648

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 1305 Troost — Length of stay in Ib 35yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location) 1305 Troost — Reside on Farm Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print) First George Middle Last Bryant

4. DATE OF DEATH Month 2/3 Day Year 59

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Feb 10 1900
9. AGE (In years Last birthday) 58 — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

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

13a. FATHER'S NAME George Bryant
13b. MOTHER'S MAIDEN NAME Sallie Clay
14. NAME OF HUSBAND OR WIFE Topeka Kan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 507-09-4689
17. INFORMANT Kathrine Young 1031 Lime Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____ — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Undetermined
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Advanced State of Decomposition + Putrefaction
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

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 a.m. p.m. Month, Day, Year
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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE L. M. Tillman M.D. Deputy Coroner
22b. ADDRESS 1618 Lydia Ave
22c. DATE SIGNED 2/3/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 2/20/59
23c. NAME OF CEMETERY OR CREMATORY Lincoln
23d. LOCATION (City, town, or county) Kansas City (State) Mo

24. FUNERAL DIRECTOR Manbolt Williams K-C-Mo ADDRESS
25. DATE RECD. BY LOCAL REG. 2-4-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

L. M. Tillman

To badly decomposed

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 Raymond Williams

Licensed Embalmer No. 4653

P. O. Address Ft. Worth

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.